

By: Senator(s) Blackwell

To: Medicaid

COMMITTEE SUBSTITUTE
FOR
SENATE BILL NO. 2867

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



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



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



137 STATES FOOD AND DRUG ADMINISTRATION (FDA) FOR THE TREATMENT OF
138 POSTPARTUM DEPRESSION; TO CREATE NEW SECTION 41-140-1, MISSISSIPPI
139 CODE OF 1972, TO DEFINE TERMS; TO CREATE NEW SECTION 41-140-3,
140 MISSISSIPPI CODE OF 1972, TO REQUIRE THE STATE DEPARTMENT OF
141 HEALTH TO DEVELOP AND PROMULGATE WRITTEN EDUCATIONAL MATERIALS AND
142 INFORMATION FOR HEALTH CARE PROFESSIONALS AND PATIENTS ABOUT
143 MATERNAL MENTAL HEALTH CONDITIONS; TO REQUIRE HOSPITALS PROVIDING
144 BIRTH SERVICES TO PROVIDE SUCH EDUCATIONAL MATERIALS TO NEW
145 PARENTS AND, AS APPROPRIATE, OTHER FAMILY MEMBERS; TO REQUIRE SUCH
146 MATERIALS BE PROVIDED TO ANY WOMAN WHO PRESENTS WITH SIGNS OF A
147 MATERNAL MENTAL HEALTH DISORDER; TO CREATE NEW SECTION 41-140-5,
148 MISSISSIPPI CODE OF 1972, TO REQUIRE ANY HEALTH CARE PROVIDER OR
149 NURSE MIDWIFE WHO RENDERS POSTNATAL CARE OR PEDIATRIC INFANT CARE
150 TO ENSURE THAT THE POSTNATAL CARE PATIENT OR BIRTHING MOTHER OF
151 THE PEDIATRIC INFANT CARE PATIENT, AS APPLICABLE, IS OFFERED
152 SCREENING FOR POSTPARTUM DEPRESSION AND TO PROVIDE APPROPRIATE
153 REFERRALS IF SUCH PATIENT OR MOTHER IS DEEMED LIKELY TO BE
154 SUFFERING FROM POSTPARTUM DEPRESSION; TO CREATE NEW SECTION
155 83-9-48, MISSISSIPPI CODE OF 1972, TO DEFINE "INSURER" AND REQUIRE
156 INSURERS TO PROVIDE COVERAGE FOR POSTPARTUM DEPRESSION SCREENING;
157 AND FOR RELATED PURPOSES.

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

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

161 43-13-115. Recipients of Medicaid shall be the following
162 persons only:

163 (1) Those who are qualified for public assistance
164 grants under provisions of Title IV-A and E of the federal Social
165 Security Act, as amended, including those statutorily deemed to be
166 IV-A and low income families and children under Section 1931 of
167 the federal Social Security Act. For the purposes of this
168 paragraph (1) and paragraphs (8), (17) and (18) of this section,
169 any reference to Title IV-A or to Part A of Title IV of the
170 federal Social Security Act, as amended, or the state plan under
171 Title IV-A or Part A of Title IV, shall be considered as a
172 reference to Title IV-A of the federal Social Security Act, as



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

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

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

192 (4) [Deleted]

193 (5) A child born on or after October 1, 1984, to a
194 woman eligible for and receiving Medicaid under the state plan on
195 the date of the child's birth shall be deemed to have applied for
196 Medicaid and to have been found eligible for Medicaid under the
197 plan on the date of that birth, and will remain eligible for



198 Medicaid for a period of one (1) year so long as the child is a
199 member of the woman's household and the woman remains eligible for
200 Medicaid or would be eligible for Medicaid if pregnant. The
201 eligibility of individuals covered in this paragraph shall be
202 determined by the Division of Medicaid.

203 (6) Children certified by the State Department of Human
204 Services to the Division of Medicaid of whom the state and county
205 departments of human services have custody and financial
206 responsibility, and children who are in adoptions subsidized in
207 full or part by the Department of Human Services, including
208 special needs children in non-Title IV-E adoption assistance, who
209 are approvable under Title XIX of the Medicaid program. The
210 eligibility of the children covered under this paragraph shall be
211 determined by the State Department of Human Services.

212 (7) Persons certified by the Division of Medicaid who
213 are patients in a medical facility (nursing home, hospital,
214 tuberculosis sanatorium or institution for treatment of mental
215 diseases), and who, except for the fact that they are patients in
216 that medical facility, would qualify for grants under Title IV,
217 Supplementary Security Income (SSI) benefits under Title XVI or
218 state supplements, and those aged, blind and disabled persons who
219 would not be eligible for Supplemental Security Income (SSI)
220 benefits under Title XVI or state supplements if they were not
221 institutionalized in a medical facility but whose income is below



222 the maximum standard set by the Division of Medicaid, which
223 standard shall not exceed that prescribed by federal regulation.

224 (8) Children under eighteen (18) years of age and
225 pregnant women (including those in intact families) who meet the
226 financial standards of the state plan approved under Title IV-A of
227 the federal Social Security Act, as amended. The eligibility of
228 children covered under this paragraph shall be determined by the
229 Division of Medicaid.

230 (9) Individuals who are:

231 (a) Children born after September 30, 1983, * * *
232 ~~who have not attained the age of~~ between the ages of six (6) and
233 nineteen (19), with family income that does not exceed * * *~~one~~
234 hundred percent (100%) ~~one hundred thirty-three percent (133%)~~ of
235 the * * *~~nonfarm official~~ federal poverty level;

236 (b) Pregnant women, infants and children * * *~~who~~
237 ~~have not attained the age of~~ between the ages of one (1) and
238 (6), with family income that does not exceed * * *~~one hundred~~
239 thirty-three percent (133%) ~~one hundred forty-three percent (143%)~~
240 of the federal poverty level; and

241 (c) Pregnant women and infants who have not
242 attained the age of one (1), with family income that does not
243 exceed * * *~~one hundred eighty-five percent (185%)~~ one hundred
244 ninety-four percent (194%) of the federal poverty level.

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



247 (10) Certain disabled children age eighteen (18) or
248 under who are living at home, who would be eligible, if in a
249 medical institution, for SSI or a state supplemental payment under
250 Title XVI of the federal Social Security Act, as amended, and
251 therefore for Medicaid under the plan, and for whom the state has
252 made a determination as required under Section 1902(e)(3)(b) of
253 the federal Social Security Act, as amended. The eligibility of
254 individuals under this paragraph shall be determined by the
255 Division of Medicaid. The division may conduct less frequent
256 medical redeterminations for children eligible under this
257 subsection who have certain long-term or chronic conditions that
258 do not need to be reidentified every year.

259 (11) * * * ~~Until the end of the day on December 31,~~
260 ~~2005,~~ Individuals who are sixty-five (65) years of age or older
261 or are disabled as determined under Section 1614(a)(3) of the
262 federal Social Security Act, as amended, and whose income does not
263 exceed one hundred thirty-five percent (135%) of the * * * ~~nonfarm~~
264 ~~official poverty level as defined by the Office of Management and~~
265 ~~Budget and revised annually~~ federal poverty level, and whose
266 resources do not exceed those established by the Division of
267 Medicaid. The eligibility of individuals covered under this
268 paragraph shall be determined by the Division of Medicaid. * * *
269 ~~After December 31, 2005,~~ Only those individuals covered under the
270 1115(c) Healthier Mississippi waiver will be covered under this
271 category.



272 Any individual who applied for Medicaid during the period
273 from July 1, 2004, through March 31, 2005, who otherwise would
274 have been eligible for coverage under this paragraph (11) if it
275 had been in effect at the time the individual submitted his or her
276 application and is still eligible for coverage under this
277 paragraph (11) on March 31, 2005, shall be eligible for Medicaid
278 coverage under this paragraph (11) from March 31, 2005, through
279 December 31, 2005. The division shall give priority in processing
280 the applications for those individuals to determine their
281 eligibility under this paragraph (11).

282 (12) Individuals who are qualified Medicare
283 beneficiaries (QMB) entitled to Part A Medicare as defined under
284 Section 301, Public Law 100-360, known as the Medicare
285 Catastrophic Coverage Act of 1988, and whose income does not
286 exceed one hundred percent (100%) of the * * * ~~nonfarm official~~
287 ~~poverty level as defined by the Office of Management and Budget~~
288 ~~and revised annually~~ federal poverty level.

289 The eligibility of individuals covered under this paragraph
290 shall be determined by the Division of Medicaid, and those
291 individuals determined eligible shall receive Medicare
292 cost-sharing expenses only as more fully defined by the Medicare
293 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
294 1997.

295 (13) (a) Individuals who are entitled to Medicare Part
296 A as defined in Section 4501 of the Omnibus Budget Reconciliation



297 Act of 1990, and whose income does not exceed one hundred twenty
298 percent (120%) of the * * * ~~nonfarm official poverty level as~~
299 ~~defined by the Office of Management and Budget and revised~~
300 annually federal poverty level. Eligibility for Medicaid benefits
301 is limited to full payment of Medicare Part B premiums.

302 (b) Individuals entitled to Part A of Medicare,
303 with income above one hundred twenty percent (120%), but less than
304 one hundred thirty-five percent (135%) of the federal poverty
305 level, and not otherwise eligible for Medicaid. Eligibility for
306 Medicaid benefits is limited to full payment of Medicare Part B
307 premiums. The number of eligible individuals is limited by the
308 availability of the federal capped allocation at one hundred
309 percent (100%) of federal matching funds, as more fully defined in
310 the Balanced Budget Act of 1997.

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

313 (14) [Deleted]

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



321 those individuals shall be entitled to buy-in coverage of Medicare
322 Part A premiums only under the provisions of this paragraph (15).

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

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

341 (18) Persons who become ineligible for assistance under
342 Title IV-A of the federal Social Security Act, as amended, as a
343 result, in whole or in part, of the collection or increased
344 collection of child or spousal support under Title IV-D of the
345 federal Social Security Act, as amended, who were eligible for



346 Medicaid for at least three (3) of the six (6) months immediately
347 preceding the month in which the ineligibility begins, shall be
348 eligible for Medicaid for an additional four (4) months beginning
349 with the month in which the ineligibility begins. The eligibility
350 of the individuals covered under this paragraph shall be
351 determined by the division.

352 (19) Disabled workers, whose incomes are above the
353 Medicaid eligibility limits, but below two hundred fifty percent
354 (250%) of the federal poverty level, shall be allowed to purchase
355 Medicaid coverage on a sliding fee scale developed by the Division
356 of Medicaid.

357 (20) Medicaid eligible children under age eighteen (18)
358 shall remain eligible for Medicaid benefits until the end of a
359 period of twelve (12) months following an eligibility
360 determination, or until such time that the individual exceeds age
361 eighteen (18).

362 (21) Women and men of * * * ~~childbearing~~ reproductive
363 age whose family income does not exceed * * * ~~one hundred~~
364 ~~eighty-five percent (185%)~~ one hundred ninety-four percent (194%)
365 of the federal poverty level. The eligibility of individuals
366 covered under this paragraph (21) shall be determined by the
367 Division of Medicaid, and those individuals determined eligible
368 shall only receive family planning services covered under Section
369 43-13-117(13) and not any other services covered under Medicaid.
370 However, any individual eligible under this paragraph (21) who is



371 also eligible under any other provision of this section shall
372 receive the benefits to which he or she is entitled under that
373 other provision, in addition to family planning services covered
374 under Section 43-13-117(13).

375 The Division of Medicaid * * * ~~shall~~ may apply to the United
376 States Secretary of Health and Human Services for a federal waiver
377 of the applicable provisions of Title XIX of the federal Social
378 Security Act, as amended, and any other applicable provisions of
379 federal law as necessary to allow for the implementation of this
380 paragraph (21). * * * ~~The provisions of this paragraph (21) shall~~
381 ~~be implemented from and after the date that the Division of~~
382 ~~Medicaid receives the federal waiver.~~

383 (22) Persons who are workers with a potentially severe
384 disability, as determined by the division, shall be allowed to
385 purchase Medicaid coverage. The term "worker with a potentially
386 severe disability" means a person who is at least sixteen (16)
387 years of age but under sixty-five (65) years of age, who has a
388 physical or mental impairment that is reasonably expected to cause
389 the person to become blind or disabled as defined under Section
390 1614(a) of the federal Social Security Act, as amended, if the
391 person does not receive items and services provided under
392 Medicaid.

393 The eligibility of persons under this paragraph (22) shall be
394 conducted as a demonstration project that is consistent with
395 Section 204 of the Ticket to Work and Work Incentives Improvement



396 Act of 1999, Public Law 106-170, for a certain number of persons
397 as specified by the division. The eligibility of individuals
398 covered under this paragraph (22) shall be determined by the
399 Division of Medicaid.

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

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

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



421 provide services to individuals who are sixty-five (65) years of
422 age or older or are disabled as determined under Section
423 1614(a)(3) of the federal Social Security Act, as amended, and
424 whose income does not exceed one hundred thirty-five percent
425 (135%) of the * * * ~~nonfarm official poverty level as defined by~~
426 ~~the Office of Management and Budget and revised annually~~ federal
427 poverty level, and whose resources do not exceed those established
428 by the Division of Medicaid, and who are not otherwise covered by
429 Medicare. Nothing contained in this paragraph (25) shall entitle
430 an individual to benefits. The eligibility of individuals covered
431 under this paragraph shall be determined by the Division of
432 Medicaid.

433 (26) * * * ~~The division shall apply to the Centers for~~
434 ~~Medicare and Medicaid Services (CMS) for any necessary waivers to~~
435 ~~provide services to individuals who are sixty-five (65) years of~~
436 ~~age or older or are disabled as determined under Section~~
437 ~~1614(a)(3) of the federal Social Security Act, as amended, who are~~
438 ~~end stage renal disease patients on dialysis, cancer patients on~~
439 ~~chemotherapy or organ transplant recipients on antirejection~~
440 ~~drugs, whose income does not exceed one hundred thirty-five~~
441 ~~percent (135%) of the nonfarm official poverty level as defined by~~
442 ~~the Office of Management and Budget and revised annually, and~~
443 ~~whose resources do not exceed those established by the division.~~
444 ~~Nothing contained in this paragraph (26) shall entitle an~~
445 ~~individual to benefits. The eligibility of individuals covered~~



446 ~~under this paragraph shall be determined by the Division of~~
447 ~~Medicaid.~~ [Deleted]

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

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

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

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

464 43-13-117. (A) Medicaid as authorized by this article shall
465 include payment of part or all of the costs, at the discretion of
466 the division, with approval of the Governor and the Centers for
467 Medicare and Medicaid Services, of the following types of care and
468 services rendered to eligible applicants who have been determined
469 to be eligible for that care and services, within the limits of
470 state appropriations and federal matching funds:



471 (1) Inpatient hospital services.

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

475 (b) No service benefits or reimbursement
476 limitations in this subsection (A)(1) shall apply to payments
477 under an APR-DRG or Ambulatory Payment Classification (APC) model
478 or a managed care program or similar model described in subsection
479 (H) of this section unless specifically authorized by the
480 division.

481 (2) Outpatient hospital services.

482 (a) Emergency services.

483 (b) Other outpatient hospital services. The
484 division shall allow benefits for other medically necessary
485 outpatient hospital services (such as chemotherapy, radiation,
486 surgery and therapy), including outpatient services in a clinic or
487 other facility that is not located inside the hospital, but that
488 has been designated as an outpatient facility by the hospital, and
489 that was in operation or under construction on July 1, 2009,
490 provided that the costs and charges associated with the operation
491 of the hospital clinic are included in the hospital's cost report.
492 In addition, the Medicare thirty-five-mile rule will apply to
493 those hospital clinics not located inside the hospital that are
494 constructed after July 1, 2009. Where the same services are
495 reimbursed as clinic services, the division may revise the rate or



496 methodology of outpatient reimbursement to maintain consistency,
497 efficiency, economy and quality of care.

498 (c) The division is authorized to implement an
499 Ambulatory Payment Classification (APC) methodology for outpatient
500 hospital services. * * * ~~The division shall give rural hospitals~~
501 ~~that have fifty (50) or fewer licensed beds the option to not be~~
502 ~~reimbursed for outpatient hospital services using the APC~~
503 ~~methodology, but reimbursement for outpatient hospital services~~
504 ~~provided by those hospitals shall be based on one hundred one~~
505 ~~percent (101%) of the rate established under Medicare for~~
506 ~~outpatient hospital services. Those hospitals choosing to not be~~
507 ~~reimbursed under the APC methodology shall remain under cost-based~~
508 ~~reimbursement for a two-year period.~~

509 (d) No service benefits or reimbursement
510 limitations in this subsection (A) (2) shall apply to payments
511 under an APR-DRG or APC model or a managed care program or similar
512 model described in subsection (H) of this section unless
513 specifically authorized by the division.

514 (3) Laboratory and x-ray services.

515 (4) Nursing facility services.

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



521 before Christmas, the day after Christmas, Thanksgiving, the day
522 before Thanksgiving and the day after Thanksgiving.

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

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

538 (d) * * * ~~On or after January 1, 2015,~~ The
539 division shall update the case-mix payment system * * * ~~resource~~
540 ~~utilization grouper and classifications~~ and fair rental
541 reimbursement system as necessary to maintain compliance with
542 federal law. The division shall develop and implement a payment
543 add-on to reimburse nursing facilities for ventilator-dependent
544 resident services.



545 (e) The division shall develop and implement, not
546 later than January 1, 2001, a case-mix payment add-on determined
547 by time studies and other valid statistical data that will
548 reimburse a nursing facility for the additional cost of caring for
549 a resident who has a diagnosis of Alzheimer's or other related
550 dementia and exhibits symptoms that require special care. Any
551 such case-mix add-on payment shall be supported by a determination
552 of additional cost. The division shall also develop and implement
553 as part of the fair rental reimbursement system for nursing
554 facility beds, an Alzheimer's resident bed depreciation enhanced
555 reimbursement system that will provide an incentive to encourage
556 nursing facilities to convert or construct beds for residents with
557 Alzheimer's or other related dementia.

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

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

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

568 (5) Periodic screening and diagnostic services for
569 individuals under age twenty-one (21) years as are needed to



570 identify physical and mental defects and to provide health care
571 treatment and other measures designed to correct or ameliorate
572 defects and physical and mental illness and conditions discovered
573 by the screening services, regardless of whether these services
574 are included in the state plan. The division may include in its
575 periodic screening and diagnostic program those discretionary
576 services authorized under the federal regulations adopted to
577 implement Title XIX of the federal Social Security Act, as
578 amended. The division, in obtaining physical therapy services,
579 occupational therapy services, and services for individuals with
580 speech, hearing and language disorders, may enter into a
581 cooperative agreement with the State Department of Education for
582 the provision of those services to handicapped students by public
583 school districts using state funds that are provided from the
584 appropriation to the Department of Education to obtain federal
585 matching funds through the division. The division, in obtaining
586 medical and mental health assessments, treatment, care and
587 services for children who are in, or at risk of being put in, the
588 custody of the Mississippi Department of Human Services may enter
589 into a cooperative agreement with the Mississippi Department of
590 Human Services for the provision of those services using state
591 funds that are provided from the appropriation to the Department
592 of Human Services to obtain federal matching funds through the
593 division.



594 (6) Physician services. Fees for physician's services
595 that are covered only by Medicaid shall be reimbursed at ninety
596 percent (90%) of the rate established on January 1, 2018, and as
597 may be adjusted each July thereafter, under Medicare. The
598 division may provide for a reimbursement rate for physician's
599 services of up to one hundred percent (100%) of the rate
600 established under Medicare for physician's services that are
601 provided after the normal working hours of the physician, as
602 determined in accordance with regulations of the division. The
603 division may reimburse eligible providers, as determined by the
604 division, for certain primary care services at one hundred percent
605 (100%) of the rate established under Medicare. The division shall
606 reimburse obstetricians * * * ~~and,~~ gynecologists and pediatricians
607 for certain primary care services as defined by the division at
608 one hundred percent (100%) of the rate established under Medicare.

609 (7) (a) Home health services for eligible persons, not
610 to exceed in cost the prevailing cost of nursing facility
611 services. All home health visits must be precertified as required
612 by the division. In addition to physicians, certified registered
613 nurse practitioners, physician assistants and clinical nurse
614 specialists are authorized to prescribe or order home health
615 services and plans of care, sign home health plans of care,
616 certify and recertify eligibility for home health services and
617 conduct the required initial face-to-face visit with the recipient
618 of the services.



619 (b) [Repealed]

620 (8) Emergency medical transportation services as
621 determined by the division.

622 (9) Prescription drugs and other covered drugs and
623 services as determined by the division.

624 The division shall establish a mandatory preferred drug list.
625 Drugs not on the mandatory preferred drug list shall be made
626 available by utilizing prior authorization procedures established
627 by the division.

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

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

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



643 Drugs prescribed for a resident of a psychiatric residential
644 treatment facility must be provided in true unit doses when
645 available. The division may require that drugs not covered by
646 Medicare Part D for a resident of a long-term care facility be
647 provided in true unit doses when available. Those drugs that were
648 originally billed to the division but are not used by a resident
649 in any of those facilities shall be returned to the billing
650 pharmacy for credit to the division, in accordance with the
651 guidelines of the State Board of Pharmacy and any requirements of
652 federal law and regulation. Drugs shall be dispensed to a
653 recipient and only one (1) dispensing fee per month may be
654 charged. The division shall develop a methodology for reimbursing
655 for restocked drugs, which shall include a restock fee as
656 determined by the division not exceeding Seven Dollars and
657 Eighty-two Cents (\$7.82).

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

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

665 All claims for drugs for dually eligible Medicare/Medicaid
666 beneficiaries that are paid for by Medicare must be submitted to



667 Medicare for payment before they may be processed by the
668 division's online payment system.

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

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

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

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



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

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

698 The division shall allow certain drugs, including
699 physician-administered drugs, and implantable drug system devices,
700 and medical supplies, with limited distribution or limited access
701 for beneficiaries and administered in an appropriate clinical
702 setting, to be reimbursed as either a medical claim or pharmacy
703 claim, as determined by the division.

704 * * * ~~It is the intent of the Legislature that the division and~~
705 ~~any managed care entity described in subsection (H) of this~~
706 ~~section encourage the use of Alpha-Hydroxyprogesterone Caproate~~
707 ~~(17P) to prevent recurrent preterm birth.~~

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

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



715 The division shall increase the amount of the reimbursement
716 rate for diagnostic and preventative dental services for each of
717 the fiscal years 2022, 2023 and 2024 by five percent (5%) above
718 the amount of the reimbursement rate for the previous fiscal year.
719 The division shall increase the amount of the reimbursement rate
720 for restorative dental services for each of the fiscal years 2023,
721 2024 and 2025 by five percent (5%) above the amount of the
722 reimbursement rate for the previous fiscal year. It is the intent
723 of the Legislature that the reimbursement rate revision for
724 preventative dental services will be an incentive to increase the
725 number of dentists who actively provide Medicaid services. This
726 dental services reimbursement rate revision shall be known as the
727 "James Russell Dumas Medicaid Dental Services Incentive Program."

728 The Medical Care Advisory Committee, assisted by the Division
729 of Medicaid, shall annually determine the effect of this incentive
730 by evaluating the number of dentists who are Medicaid providers,
731 the number who and the degree to which they are actively billing
732 Medicaid, the geographic trends of where dentists are offering
733 what types of Medicaid services and other statistics pertinent to
734 the goals of this legislative intent. This data shall annually be
735 presented to the Chair of the Senate Medicaid Committee and the
736 Chair of the House Medicaid Committee.

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



740 (11) Eyeglasses for all Medicaid beneficiaries who have
741 (a) had surgery on the eyeball or ocular muscle that results in a
742 vision change for which eyeglasses or a change in eyeglasses is
743 medically indicated within six (6) months of the surgery and is in
744 accordance with policies established by the division, or (b) one
745 (1) pair every * * * ~~five (5)~~ two (2) years and in accordance with
746 policies established by the division. In either instance, the
747 eyeglasses must be prescribed by a physician skilled in diseases
748 of the eye or an optometrist, whichever the beneficiary may
749 select.

750 (12) Intermediate care facility services.

751 (a) The division shall make full payment to all
752 intermediate care facilities for individuals with intellectual
753 disabilities for each day, not exceeding sixty-three (63) days per
754 year, that a patient is absent from the facility on home leave.
755 Payment may be made for the following home leave days in addition
756 to the sixty-three-day limitation: Christmas, the day before
757 Christmas, the day after Christmas, Thanksgiving, the day before
758 Thanksgiving and the day after Thanksgiving.

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

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



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

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

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

775 (b) Dialysis center services.

776 Ambulatory Surgical Care (ASCs) may be reimbursed by the
777 division based on one hundred percent (100%) of the Medicare ASC
778 Payment System rate in effect July 1 of each year as set by the
779 Center for Medicare and Medicaid Services.

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

785 (16) Mental health services. Certain services provided
786 by a psychiatrist shall be reimbursed at up to one hundred percent
787 (100%) of the Medicare rate. Approved therapeutic and case
788 management services (a) provided by an approved regional mental
789 health/intellectual disability center established under Sections



790 41-19-31 through 41-19-39, or by another community mental health
791 service provider meeting the requirements of the Department of
792 Mental Health to be an approved mental health/intellectual
793 disability center if determined necessary by the Department of
794 Mental Health, using state funds that are provided in the
795 appropriation to the division to match federal funds, or (b)
796 provided by a facility that is certified by the State Department
797 of Mental Health to provide therapeutic and case management
798 services, to be reimbursed on a fee for service basis, or (c)
799 provided in the community by a facility or program operated by the
800 Department of Mental Health. Any such services provided by a
801 facility described in subparagraph (b) must have the prior
802 approval of the division to be reimbursable under this section.

803 (17) Durable medical equipment services and medical
804 supplies. Precertification of durable medical equipment and
805 medical supplies must be obtained as required by the division.
806 The Division of Medicaid may require durable medical equipment
807 providers to obtain a surety bond in the amount and to the
808 specifications as established by the Balanced Budget Act of 1997.
809 A maximum dollar amount of reimbursement for noninvasive
810 ventilators or ventilation treatments properly ordered and being
811 used in an appropriate care setting shall not be set by any health
812 maintenance organization, coordinated care organization,
813 provider-sponsored health plan, or other organization paid for
814 services on a capitated basis by the division under any managed



815 care program or coordinated care program implemented by the
816 division under this section. Reimbursement by these organizations
817 to durable medical equipment suppliers for home use of noninvasive
818 and invasive ventilators shall be on a continuous monthly payment
819 basis for the duration of medical need throughout a patient's
820 valid prescription period.

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

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



839 (b) (i) 1. The division may establish a Medicare
840 Upper Payment Limits Program, as defined in Section 1902(a)(30) of
841 the federal Social Security Act and any applicable federal
842 regulations, or an allowable delivery system or provider payment
843 initiative authorized under 42 CFR 438.6(c), for hospitals,
844 nursing facilities * * * ~~and,~~ physicians and other eligible
845 licensed providers as determined by the division employed or
846 contracted by hospitals.

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

853 (ii) The division shall assess each hospital,
854 nursing facility, and emergency ambulance transportation provider
855 for the sole purpose of financing the state portion of the
856 Medicare Upper Payment Limits Program or other program(s)
857 authorized under this subsection (A)(18)(b). The hospital
858 assessment shall be as provided in Section 43-13-145(4)(a), and
859 the nursing facility and the emergency ambulance transportation
860 assessments, if established, shall be based on Medicaid
861 utilization or other appropriate method, as determined by the
862 division, consistent with federal regulations. The assessments
863 will remain in effect as long as the state participates in the



864 Medicare Upper Payment Limits Program or other program(s)
865 authorized under this subsection (A)(18)(b). In addition to the
866 hospital assessment provided in Section 43-13-145(4)(a), hospitals
867 with physicians and other eligible licensed providers as
868 determined by the division participating in the Medicare Upper
869 Payment Limits Program or other program(s) authorized under this
870 subsection (A)(18)(b) shall be required to participate in an
871 intergovernmental transfer or assessment, as determined by the
872 division, for the purpose of financing the state portion of the
873 physician UPL payments or other payment(s) authorized under this
874 subsection (A)(18)(b).

875 (iii) Subject to approval by the Centers for
876 Medicare and Medicaid Services (CMS) and the provisions of this
877 subsection (A)(18)(b), the division shall make additional
878 reimbursement to hospitals, nursing facilities, and emergency
879 ambulance transportation providers for the Medicare Upper Payment
880 Limits Program or other program(s) authorized under this
881 subsection (A)(18)(b), and, if the program is established for
882 physicians and other eligible licensed providers as determined by
883 the division, shall make additional reimbursement for physicians
884 and other eligible licensed providers as determined by the
885 division, as defined in Section 1902(a)(30) of the federal Social
886 Security Act and any applicable federal regulations, provided the
887 assessment in this subsection (A)(18)(b) is in effect.



888 (iv) * * * ~~Notwithstanding any other~~
889 ~~provision of this article to the contrary, effective upon~~
890 ~~implementation of the Mississippi Hospital Access Program (MHAP)~~
891 ~~provided in subparagraph (c)(i) below, the hospital portion of the~~
892 ~~inpatient Upper Payment Limits Program shall transition into and~~
893 ~~be replaced by the MHAP program. However, The division is~~
894 ~~authorized to develop and implement an alternative fee-for-service~~
895 ~~Upper Payment Limits model in accordance with federal laws and~~
896 ~~regulations if necessary to preserve supplemental funding. * * *~~
897 ~~Further, the division, in consultation with the hospital industry~~
898 ~~shall develop alternative models for distribution of medical~~
899 ~~claims and supplemental payments for inpatient and outpatient~~
900 ~~hospital services, and such models may include, but shall not be~~
901 ~~limited to the following: increasing rates for inpatient and~~
902 ~~outpatient services; creating a low-income utilization pool of~~
903 ~~funds to reimburse hospitals for the costs of uncompensated care,~~
904 ~~charity care and bad debts as permitted and approved pursuant to~~
905 ~~federal regulations and the Centers for Medicare and Medicaid~~
906 ~~Services; supplemental payments based upon Medicaid utilization,~~
907 ~~quality, service lines and/or costs of providing such services to~~
908 ~~Medicaid beneficiaries and to uninsured patients. The goals of~~
909 ~~such payment models shall be to ensure access to inpatient and~~
910 ~~outpatient care and to maximize any federal funds that are~~
911 ~~available to reimburse hospitals for services provided. Any such~~
912 ~~documents required to achieve the goals described in this~~



913 ~~paragraph shall be submitted to the Centers for Medicare and~~
914 ~~Medicaid Services, with a proposed effective date of July 1, 2019,~~
915 ~~to the extent possible, but in no event shall the effective date~~
916 ~~of such payment models be later than July 1, 2020. The Chairmen~~
917 ~~of the Senate and House Medicaid Committees shall be provided a~~
918 ~~copy of the proposed payment model(s) prior to submission.~~
919 ~~Effective July 1, 2018, and until such time as any payment~~
920 ~~model(s) as described above become effective, the division, in~~
921 ~~consultation with the hospital industry, is authorized to~~
922 ~~implement a transitional program for inpatient and outpatient~~
923 ~~payments and/or supplemental payments (including, but not limited~~
924 ~~to, MHAP and directed payments), to redistribute available~~
925 ~~supplemental funds among hospital providers, provided that when~~
926 ~~compared to a hospital's prior year supplemental payments,~~
927 ~~supplemental payments made pursuant to any such transitional~~
928 ~~program shall not result in a decrease of more than five percent~~
929 ~~(5%) and shall not increase by more than the amount needed to~~
930 ~~maximize the distribution of the available funds. The division,~~
931 ~~in consultation with the Mississippi Hospital Association, may~~
932 ~~develop alternative models for distribution of medical claims and~~
933 ~~supplemental payments for inpatient and outpatient hospital~~
934 ~~services, and such models may include, but shall not be limited~~
935 ~~to, the following: increasing rates for inpatient and outpatient~~
936 ~~services; creating a low-income utilization pool of funds to~~
937 ~~reimburse hospitals for the costs of uncompensated care, charity~~



938 care and bad debts as permitted and approved pursuant to federal
939 regulations and the Centers for Medicare and Medicaid Services;
940 supplemental payments based upon Medicaid utilization, quality,
941 service lines and/or costs of providing such services to Medicaid
942 beneficiaries and to uninsured patients. The goals of such
943 payment models shall be to ensure access to inpatient and
944 outpatient care and to maximize any federal funds that are
945 available to reimburse hospitals for services provided. The
946 Chairmen of the Senate and House Medicaid Committees shall be
947 provided copies of the proposed payment model(s) prior to
948 submission.

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

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



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

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

977 c. As used in this paragraph
978 (18)(b)(v), the term "upper payment limit gap" means the
979 difference between the total amount that the ambulance
980 transportation service provider received from Medicaid and the
981 average amount that the ambulance transportation service provider
982 would have received from commercial insurers for those services
983 reimbursed by Medicaid.

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



987 (c) (i) * * * ~~Not later than December 1, 2015,~~
988 The division shall, subject to approval by the Centers for
989 Medicare and Medicaid Services (CMS), establish, implement and
990 operate a Mississippi Hospital Access Program (MHAP) for the
991 purpose of protecting patient access to hospital care through
992 hospital inpatient reimbursement programs provided in this section
993 designed to maintain total hospital reimbursement for inpatient
994 services rendered by in-state hospitals and the out-of-state
995 hospital that is authorized by federal law to submit
996 intergovernmental transfers (IGTs) to the State of Mississippi and
997 is classified as Level I trauma center located in a county
998 contiguous to the state line at the maximum levels permissible
999 under applicable federal statutes and regulations * * *, ~~at which~~
1000 ~~time the current inpatient Medicare Upper Payment Limits (UPL)~~
1001 ~~Program for hospital inpatient services shall transition to the~~
1002 ~~MHAP.~~

1003 (ii) Subject to approval by the Centers for
1004 Medicare and Medicaid Services (CMS), the MHAP shall provide
1005 increased inpatient capitation (PMPM) payments to managed care
1006 entities contracting with the division pursuant to subsection (H)
1007 of this section to support availability of hospital services or
1008 such other payments permissible under federal law necessary to
1009 accomplish the intent of this subsection.

1010 (iii) The intent of this subparagraph (c) is
1011 that effective for all inpatient hospital Medicaid services during



1012 state fiscal year 2016, and so long as this provision shall remain
1013 in effect hereafter, the division * * * ~~shall~~ may, to the fullest
1014 extent feasible, l replace the additional reimbursement for hospital
1015 inpatient services under the inpatient Medicare Upper Payment
1016 Limits (UPL) Program with additional reimbursement under the MHAP
1017 and other payment programs for inpatient and/or outpatient
1018 payments which may be developed under the authority of this
1019 paragraph.

1020 (iv) The division shall assess each hospital
1021 as provided in Section 43-13-145(4) (a) for the purpose of
1022 financing the state portion of the MHAP, supplemental payments and
1023 such other purposes as specified in Section 43-13-145. The
1024 assessment will remain in effect as long as the MHAP and
1025 supplemental payments are in effect.

1026 (19) (a) Perinatal riskumanagement services. The
1027 division shall promulgate regulations to be effective from and
1028 after October 1, 1988, to establish a comprehensive perinatal
1029 system for risk assessment of all pregnant and infant Medicaid
1030 recipients and for management, education and follow-up for those
1031 who are determined to be at risk. Services to be performed
1032 include case management, nutrition assessment/counseling,
1033 psychosocial assessment/counseling and health education. The
1034 division * * * ~~shall~~ may contract with the State Department of
1035 Health to provide services within this paragraph (Perinatal High
1036 Risk Management/Infant Services System (PHRM/ISS)) for any



1037 eligible beneficiary who cannot receive these services under a
1038 different program. The State Department of Health shall be
1039 reimbursed on a full reasonable cost basis for services provided
1040 under this subparagraph (a). Any program authorized under
1041 subsection H of this section shall develop a perinatal
1042 risk-management services program in consultation with the division
1043 and the State Department of Health or may contract with the State
1044 Department of Health for these services, and the programs shall
1045 begin providing these services no later than January 1, 2026.

1046 (b) Early intervention system services. The
1047 division shall cooperate with the State Department of Health,
1048 acting as lead agency, in the development and implementation of a
1049 statewide system of delivery of early intervention services, under
1050 Part C of the Individuals with Disabilities Education Act (IDEA).
1051 The State Department of Health shall certify annually in writing
1052 to the executive director of the division the dollar amount of
1053 state early intervention funds available that will be utilized as
1054 a certified match for Medicaid matching funds. Those funds then
1055 shall be used to provide expanded targeted case management
1056 services for Medicaid eligible children with special needs who are
1057 eligible for the state's early intervention system.
1058 Qualifications for persons providing service coordination shall be
1059 determined by the State Department of Health and the Division of
1060 Medicaid.



1061 (20) Home- and community-based services for physically
1062 disabled approved services as allowed by a waiver from the United
1063 States Department of Health and Human Services for home- and
1064 community-based services for physically disabled people using
1065 state funds that are provided from the appropriation to the State
1066 Department of Rehabilitation Services and used to match federal
1067 funds under a cooperative agreement between the division and the
1068 department, provided that funds for these services are
1069 specifically appropriated to the Department of Rehabilitation
1070 Services.

1071 (21) Nurse practitioner services. Services furnished
1072 by a registered nurse who is licensed and certified by the
1073 Mississippi Board of Nursing as a nurse practitioner, including,
1074 but not limited to, nurse anesthetists, nurse midwives, family
1075 nurse practitioners, family planning nurse practitioners,
1076 pediatric nurse practitioners, obstetrics-gynecology nurse
1077 practitioners and neonatal nurse practitioners, under regulations
1078 adopted by the division. Reimbursement for those services shall
1079 not exceed ninety percent (90%) of the reimbursement rate for
1080 comparable services rendered by a physician. The division may
1081 provide for a reimbursement rate for nurse practitioner services
1082 of up to one hundred percent (100%) of the reimbursement rate for
1083 comparable services rendered by a physician for nurse practitioner
1084 services that are provided after the normal working hours of the



1085 nurse practitioner, as determined in accordance with regulations
1086 of the division.

1087 (22) Ambulatory services delivered in federally
1088 qualified health centers, rural health centers and clinics of the
1089 local health departments of the State Department of Health for
1090 individuals eligible for Medicaid under this article based on
1091 reasonable costs as determined by the division. Federally
1092 qualified health centers shall be reimbursed by the Medicaid
1093 prospective payment system as approved by the Centers for Medicare
1094 and Medicaid Services. The division shall recognize federally
1095 qualified health centers (FQHCs), rural health clinics (RHCs) and
1096 community mental health centers (CMHCs) as both an originating and
1097 distant site provider for the purposes of telehealth
1098 reimbursement. The division is further authorized and directed to
1099 reimburse FQHCs, RHCs and CMHCs for both distant site and
1100 originating site services when such services are appropriately
1101 provided by the same organization.

1102 (23) Inpatient psychiatric services.

1103 (a) Inpatient psychiatric services to be
1104 determined by the division for recipients under age twenty-one
1105 (21) that are provided under the direction of a physician in an
1106 inpatient program in a licensed acute care psychiatric facility or
1107 in a licensed psychiatric residential treatment facility, before
1108 the recipient reaches age twenty-one (21) or, if the recipient was
1109 receiving the services immediately before he or she reached age



1110 twenty-one (21), before the earlier of the date he or she no
1111 longer requires the services or the date he or she reaches age
1112 twenty-two (22), as provided by federal regulations. From and
1113 after January 1, 2015, the division shall update the fair rental
1114 reimbursement system for psychiatric residential treatment
1115 facilities. Precertification of inpatient days and residential
1116 treatment days must be obtained as required by the division. From
1117 and after July 1, 2009, all state-owned and state-operated
1118 facilities that provide inpatient psychiatric services to persons
1119 under age twenty-one (21) who are eligible for Medicaid
1120 reimbursement shall be reimbursed for those services on a full
1121 reasonable cost basis.

1122 (b) The division may reimburse for services
1123 provided by a licensed freestanding psychiatric hospital to
1124 Medicaid recipients over the age of twenty-one (21) in a method
1125 and manner consistent with the provisions of Section 43-13-117.5.

1126 (24) * * *—[Deleted] Certified Community Behavioral
1127 Health Centers (CCBHCs). The division may reimburse CCBHCs in a
1128 manner as determined by the division.

1129 (25) [Deleted]

1130 (26) Hospice care. As used in this paragraph, the term
1131 "hospice care" means a coordinated program of active professional
1132 medical attention within the home and outpatient and inpatient
1133 care that treats the terminally ill patient and family as a unit,
1134 employing a medically directed interdisciplinary team. The



1135 program provides relief of severe pain or other physical symptoms
1136 and supportive care to meet the special needs arising out of
1137 physical, psychological, spiritual, social and economic stresses
1138 that are experienced during the final stages of illness and during
1139 dying and bereavement and meets the Medicare requirements for
1140 participation as a hospice as provided in federal regulations.

1141 (27) Group health plan premiums and cost-sharing if it
1142 is cost-effective as defined by the United States Secretary of
1143 Health and Human Services.

1144 (28) Other health insurance premiums that are
1145 cost-effective as defined by the United States Secretary of Health
1146 and Human Services. Medicare eligible must have Medicare Part B
1147 before other insurance premiums can be paid.

1148 (29) The Division of Medicaid may apply for a waiver
1149 from the United States Department of Health and Human Services for
1150 home- and community-based services for developmentally disabled
1151 people using state funds that are provided from the appropriation
1152 to the State Department of Mental Health and/or funds transferred
1153 to the department by a political subdivision or instrumentality of
1154 the state and used to match federal funds under a cooperative
1155 agreement between the division and the department, provided that
1156 funds for these services are specifically appropriated to the
1157 Department of Mental Health and/or transferred to the department
1158 by a political subdivision or instrumentality of the state.



1159 (30) Pediatric skilled nursing services as determined
1160 by the division and in a manner consistent with regulations
1161 promulgated by the Mississippi State Department of Health.

1162 (31) Targeted case management services for children
1163 with special needs, under waivers from the United States
1164 Department of Health and Human Services, using state funds that
1165 are provided from the appropriation to the Mississippi Department
1166 of Human Services and used to match federal funds under a
1167 cooperative agreement between the division and the department.

1168 (32) Care and services provided in Christian Science
1169 Sanatoria listed and certified by the Commission for Accreditation
1170 of Christian Science Nursing Organizations/Facilities, Inc.,
1171 rendered in connection with treatment by prayer or spiritual means
1172 to the extent that those services are subject to reimbursement
1173 under Section 1903 of the federal Social Security Act.

1174 (33) Podiatrist services.

1175 (34) Assisted living services as provided through
1176 home- and community-based services under Title XIX of the federal
1177 Social Security Act, as amended, subject to the availability of
1178 funds specifically appropriated for that purpose by the
1179 Legislature.

1180 (35) Services and activities authorized in Sections
1181 43-27-101 and 43-27-103, using state funds that are provided from
1182 the appropriation to the Mississippi Department of Human Services



1183 and used to match federal funds under a cooperative agreement
1184 between the division and the department.

1185 (36) Nonemergency transportation services for
1186 Medicaid-eligible persons as determined by the division. The PEER
1187 Committee shall conduct a performance evaluation of the
1188 nonemergency transportation program to evaluate the administration
1189 of the program and the providers of transportation services to
1190 determine the most cost-effective ways of providing nonemergency
1191 transportation services to the patients served under the program.
1192 The performance evaluation shall be completed and provided to the
1193 members of the Senate Medicaid Committee and the House Medicaid
1194 Committee not later than January 1, 2019, and every two (2) years
1195 thereafter.

1196 (37) [Deleted]

1197 (38) Chiropractic services. A chiropractor's manual
1198 manipulation of the spine to correct a subluxation, if x-ray
1199 demonstrates that a subluxation exists and if the subluxation has
1200 resulted in a neuromusculoskeletal condition for which
1201 manipulation is appropriate treatment, and related spinal x-rays
1202 performed to document these conditions. Reimbursement for
1203 chiropractic services shall not exceed Seven Hundred Dollars
1204 (\$700.00) per year per beneficiary.

1205 (39) Dually eligible Medicare/Medicaid beneficiaries.
1206 The division shall pay the Medicare deductible and coinsurance
1207 amounts for services available under Medicare, as determined by



1208 the division. From and after July 1, 2009, the division shall
1209 reimburse crossover claims for inpatient hospital services and
1210 crossover claims covered under Medicare Part B in the same manner
1211 that was in effect on January 1, 2008, unless specifically
1212 authorized by the Legislature to change this method.

1213 (40) [Deleted]

1214 (41) Services provided by the State Department of
1215 Rehabilitation Services for the care and rehabilitation of persons
1216 with spinal cord injuries or traumatic brain injuries, as allowed
1217 under waivers from the United States Department of Health and
1218 Human Services, using up to seventy-five percent (75%) of the
1219 funds that are appropriated to the Department of Rehabilitation
1220 Services from the Spinal Cord and Head Injury Trust Fund
1221 established under Section 37-33-261 and used to match federal
1222 funds under a cooperative agreement between the division and the
1223 department.

1224 (42) [Deleted]

1225 (43) The division shall provide reimbursement,
1226 according to a payment schedule developed by the division, for
1227 smoking cessation medications for pregnant women during their
1228 pregnancy and other Medicaid-eligible women who are of
1229 child-bearing age.

1230 (44) Nursing facility services for the severely
1231 disabled.



1232 (a) Severe disabilities include, but are not
1233 limited to, spinal cord injuries, closed-head injuries and
1234 ventilator-dependent patients.

1235 (b) Those services must be provided in a long-term
1236 care nursing facility dedicated to the care and treatment of
1237 persons with severe disabilities.

1238 (45) Physician assistant services. Services furnished
1239 by a physician assistant who is licensed by the State Board of
1240 Medical Licensure and is practicing with physician supervision
1241 under regulations adopted by the board, under regulations adopted
1242 by the division. Reimbursement for those services shall not
1243 exceed ninety percent (90%) of the reimbursement rate for
1244 comparable services rendered by a physician. The division may
1245 provide for a reimbursement rate for physician assistant services
1246 of up to one hundred percent (100%) or the reimbursement rate for
1247 comparable services rendered by a physician for physician
1248 assistant services that are provided after the normal working
1249 hours of the physician assistant, as determined in accordance with
1250 regulations of the division.

1251 (46) The division shall make application to the federal
1252 Centers for Medicare and Medicaid Services (CMS) for a waiver to
1253 develop and provide services for children with serious emotional
1254 disturbances as defined in Section 43-14-1(1), which may include
1255 home- and community-based services, case management services or
1256 managed care services through mental health providers certified by



1257 the Department of Mental Health. The division may implement and
1258 provide services under this waived program only if funds for
1259 these services are specifically appropriated for this purpose by
1260 the Legislature, or if funds are voluntarily provided by affected
1261 agencies.

1262 (47) (a) The division may develop and implement
1263 disease management programs for individuals with high-cost chronic
1264 diseases and conditions, including the use of grants, waivers,
1265 demonstrations or other projects as necessary.

1266 (b) Participation in any disease management
1267 program implemented under this paragraph (47) is optional with the
1268 individual. An individual must affirmatively elect to participate
1269 in the disease management program in order to participate, and may
1270 elect to discontinue participation in the program at any time.

1271 (48) Pediatric long-term acute care hospital services.

1272 (a) Pediatric long-term acute care hospital
1273 services means services provided to eligible persons under
1274 twenty-one (21) years of age by a freestanding Medicare-certified
1275 hospital that has an average length of inpatient stay greater than
1276 twenty-five (25) days and that is primarily engaged in providing
1277 chronic or long-term medical care to persons under twenty-one (21)
1278 years of age.

1279 (b) The services under this paragraph (48) shall
1280 be reimbursed as a separate category of hospital services.



1281 (49) The division may establish copayments and/or
1282 coinsurance for any Medicaid services for which copayments and/or
1283 coinsurance are allowable under federal law or regulation.

1284 (50) Services provided by the State Department of
1285 Rehabilitation Services for the care and rehabilitation of persons
1286 who are deaf and blind, as allowed under waivers from the United
1287 States Department of Health and Human Services to provide home-
1288 and community-based services using state funds that are provided
1289 from the appropriation to the State Department of Rehabilitation
1290 Services or if funds are voluntarily provided by another agency.

1291 (51) Upon determination of Medicaid eligibility and in
1292 association with annual redetermination of Medicaid eligibility,
1293 beneficiaries shall be encouraged to undertake a physical
1294 examination that will establish a base-line level of health and
1295 identification of a usual and customary source of care (a medical
1296 home) to aid utilization of disease management tools. This
1297 physical examination and utilization of these disease management
1298 tools shall be consistent with current United States Preventive
1299 Services Task Force or other recognized authority recommendations.

1300 For persons who are determined ineligible for Medicaid, the
1301 division will provide information and direction for accessing
1302 medical care and services in the area of their residence.

1303 (52) Notwithstanding any provisions of this article,
1304 the division may pay enhanced reimbursement fees related to trauma
1305 care, as determined by the division in conjunction with the State



1306 Department of Health, using funds appropriated to the State
1307 Department of Health for trauma care and services and used to
1308 match federal funds under a cooperative agreement between the
1309 division and the State Department of Health. The division, in
1310 conjunction with the State Department of Health, may use grants,
1311 waivers, demonstrations, enhanced reimbursements, Upper Payment
1312 Limits Programs, supplemental payments, or other projects as
1313 necessary in the development and implementation of this
1314 reimbursement program.

1315 (53) Targeted case management services for high-cost
1316 beneficiaries may be developed by the division for all services
1317 under this section.

1318 (54) [Deleted]

1319 (55) Therapy services. The plan of care for therapy
1320 services may be developed to cover a period of treatment for up to
1321 six (6) months, but in no event shall the plan of care exceed a
1322 six-month period of treatment. The projected period of treatment
1323 must be indicated on the initial plan of care and must be updated
1324 with each subsequent revised plan of care. Based on medical
1325 necessity, the division shall approve certification periods for
1326 less than or up to six (6) months, but in no event shall the
1327 certification period exceed the period of treatment indicated on
1328 the plan of care. The appeal process for any reduction in therapy
1329 services shall be consistent with the appeal process in federal
1330 regulations.



1331 (56) Prescribed pediatric extended care centers
1332 services for medically dependent or technologically dependent
1333 children with complex medical conditions that require continual
1334 care as prescribed by the child's attending physician, as
1335 determined by the division.

1336 (57) No Medicaid benefit shall restrict coverage for
1337 medically appropriate treatment prescribed by a physician and
1338 agreed to by a fully informed individual, or if the individual
1339 lacks legal capacity to consent by a person who has legal
1340 authority to consent on his or her behalf, based on an
1341 individual's diagnosis with a terminal condition. As used in this
1342 paragraph (57), "terminal condition" means any aggressive
1343 malignancy, chronic end-stage cardiovascular or cerebral vascular
1344 disease, or any other disease, illness or condition which a
1345 physician diagnoses as terminal.

1346 (58) Treatment services for persons with opioid
1347 dependency or other highly addictive substance use disorders. The
1348 division is authorized to reimburse eligible providers for
1349 treatment of opioid dependency and other highly addictive
1350 substance use disorders, as determined by the division. Treatment
1351 related to these conditions shall not count against any physician
1352 visit limit imposed under this section.

1353 (59) The division shall allow beneficiaries between the
1354 ages of ten (10) and eighteen (18) years to receive vaccines
1355 through a pharmacy venue. The division and the State Department



1356 of Health shall coordinate and notify OB-GYN providers that the
1357 Vaccines for Children program is available to providers free of
1358 charge.

1359 (60) Border city university-affiliated pediatric
1360 teaching hospital.

1361 (a) Payments may only be made to a border city
1362 university-affiliated pediatric teaching hospital if the Centers
1363 for Medicare and Medicaid Services (CMS) approve an increase in
1364 the annual request for the provider payment initiative authorized
1365 under 42 CFR Section 438.6(c) in an amount equal to or greater
1366 than the estimated annual payment to be made to the border city
1367 university-affiliated pediatric teaching hospital. The estimate
1368 shall be based on the hospital's prior year Mississippi managed
1369 care utilization.

1370 (b) As used in this paragraph (60), the term
1371 "border city university-affiliated pediatric teaching hospital"
1372 means an out-of-state hospital located within a city bordering the
1373 eastern bank of the Mississippi River and the State of Mississippi
1374 that submits to the division a copy of a current and effective
1375 affiliation agreement with an accredited university and other
1376 documentation establishing that the hospital is
1377 university-affiliated, is licensed and designated as a pediatric
1378 hospital or pediatric primary hospital within its home state,
1379 maintains at least five (5) different pediatric specialty training
1380 programs, and maintains at least one hundred (100) operated beds



1381 dedicated exclusively for the treatment of patients under the age
1382 of twenty-one (21) years.

1383 (c) The cost of providing services to Mississippi
1384 Medicaid beneficiaries under the age of twenty-one (21) years who
1385 are treated by a border city university-affiliated pediatric
1386 teaching hospital shall not exceed the cost of providing the same
1387 services to individuals in hospitals in the state.

1388 (d) It is the intent of the Legislature that
1389 payments shall not result in any in-state hospital receiving
1390 payments lower than they would otherwise receive if not for the
1391 payments made to any border city university-affiliated pediatric
1392 teaching hospital.

1393 (e) This paragraph (60) shall stand repealed on
1394 July 1, * * * ~~2028~~ 2029.

1395 (61) Autism spectrum disorder services. The division
1396 shall develop and implement a method for reimbursement of autism
1397 spectrum disorder services based on a continuum of care for best
1398 practices in medically necessary early intervention treatment.
1399 The division shall work in consultation with the Department of
1400 Mental Health, healthcare providers, the Autism Advisory
1401 Committee, and other stakeholders relevant to the autism industry
1402 to develop these reimbursement rates. The requirements of this
1403 subsection shall apply to any autism spectrum disorder services
1404 rendered under the authority of the Medicaid State Plan and any
1405 Home and Community Based Services Waiver authorized under this



1406 section through which autism spectrum disorder services are
1407 provided.

1408 (62) Preparticipation physical evaluations. The
1409 division shall reimburse for preparticipation physical evaluations
1410 of beneficiaries in a manner as determined by the division.

1411 (63) Glucagon-like peptide-1 (GLP-1) agonist
1412 medications that have been approved for chronic weight management
1413 by the United States Food and Drug Administration (FDA). The
1414 division shall, in a manner as determined by the division,
1415 reimburse for FDA-approved GLP-1 agonist medications prescribed
1416 for chronic weight management and/or for management of additional
1417 conditions in the discretion of the medical provider.

1418 (64) Coverage and reimbursement for postpartum
1419 depression screening. The division and any managed care entity
1420 described in subsection (H) of this section shall provide coverage
1421 for postpartum depression screening required pursuant to Section
1422 41-140-5. Such coverage shall provide for additional
1423 reimbursement for the administration of postpartum depression
1424 screening adequate to compensate the health care provider for the
1425 provision of such screening and consistent with ensuring broad
1426 access to postpartum depression screening in line with
1427 evidence-based guidelines.

1428 (65) Nonstatin medications. The division shall provide
1429 coverage and reimbursement, in a manner as determined by the
1430 division, for any nonstatin medication that has a unique



1431 indication to reduce the risk of a major cardiovascular event in
1432 primary prevention and secondary prevention patients.

1433 (B) Planning and development districts participating in the
1434 home- and community-based services program for the elderly and
1435 disabled as case management providers shall be reimbursed for case
1436 management services at the maximum rate approved by the Centers
1437 for Medicare and Medicaid Services (CMS).

1438 (C) The division may pay to those providers who participate
1439 in and accept patient referrals from the division's emergency room
1440 redirection program a percentage, as determined by the division,
1441 of savings achieved according to the performance measures and
1442 reduction of costs required of that program. Federally qualified
1443 health centers may participate in the emergency room redirection
1444 program, and the division may pay those centers a percentage of
1445 any savings to the Medicaid program achieved by the centers'
1446 accepting patient referrals through the program, as provided in
1447 this subsection (C).

1448 (D) (1) As used in this subsection (D), the following terms
1449 shall be defined as provided in this paragraph, except as
1450 otherwise provided in this subsection:

1451 (a) "Committees" means the Medicaid Committees of
1452 the House of Representatives and the Senate, and "committee" means
1453 either one of those committees.

1454 (b) "Rate change" means an increase, decrease or
1455 other change in the payments or rates of reimbursement, or a



1456 change in any payment methodology that results in an increase,
1457 decrease or other change in the payments or rates of
1458 reimbursement, to any Medicaid provider that renders any services
1459 authorized to be provided to Medicaid recipients under this
1460 article.

1461 (2) Whenever the Division of Medicaid proposes a rate
1462 change, the division shall give notice to the chairmen of the
1463 committees at least * * * ~~thirty (30)~~ fifteen (15) calendar days
1464 before the proposed rate change is scheduled to take effect. The
1465 division shall furnish the chairmen with a concise summary of each
1466 proposed rate change along with the notice, and shall furnish the
1467 chairmen with a copy of any proposed rate change upon request.
1468 The division also shall provide a summary and copy of any proposed
1469 rate change to any other member of the Legislature upon request.

1470 (3) If the chairman of either committee or both
1471 chairmen jointly object to the proposed rate change or any part
1472 thereof, the chairman or chairmen shall notify the division and
1473 provide the reasons for their objection in writing not later than
1474 seven (7) calendar days after receipt of the notice from the
1475 division. The chairman or chairmen may make written
1476 recommendations to the division for changes to be made to a
1477 proposed rate change.

1478 (4) (a) The chairman of either committee or both
1479 chairmen jointly may hold a committee meeting to review a proposed
1480 rate change. If either chairman or both chairmen decide to hold a



1481 meeting, they shall notify the division of their intention in
1482 writing within seven (7) calendar days after receipt of the notice
1483 from the division, and shall set the date and time for the meeting
1484 in their notice to the division, which shall not be later than
1485 fourteen (14) calendar days after receipt of the notice from the
1486 division.

1487 (b) After the committee meeting, the committee or
1488 committees may object to the proposed rate change or any part
1489 thereof. The committee or committees shall notify the division
1490 and the reasons for their objection in writing not later than
1491 seven (7) calendar days after the meeting. The committee or
1492 committees may make written recommendations to the division for
1493 changes to be made to a proposed rate change.

1494 (5) If both chairmen notify the division in writing
1495 within seven (7) calendar days after receipt of the notice from
1496 the division that they do not object to the proposed rate change
1497 and will not be holding a meeting to review the proposed rate
1498 change, the proposed rate change will take effect on the original
1499 date as scheduled by the division or on such other date as
1500 specified by the division.

1501 (6) (a) If there are any objections to a proposed rate
1502 change or any part thereof from either or both of the chairmen or
1503 the committees, the division may withdraw the proposed rate
1504 change, make any of the recommended changes to the proposed rate
1505 change, or not make any changes to the proposed rate change.



1506 (b) If the division does not make any changes to
1507 the proposed rate change, it shall notify the chairmen of that
1508 fact in writing, and the proposed rate change shall take effect on
1509 the original date as scheduled by the division or on such other
1510 date as specified by the division.

1511 (c) If the division makes any changes to the
1512 proposed rate change, the division shall notify the chairmen of
1513 its actions in writing, and the revised proposed rate change shall
1514 take effect on the date as specified by the division.

1515 (7) Nothing in this subsection (D) shall be construed
1516 as giving the chairmen or the committees any authority to veto,
1517 nullify or revise any rate change proposed by the division. The
1518 authority of the chairmen or the committees under this subsection
1519 shall be limited to reviewing, making objections to and making
1520 recommendations for changes to rate changes proposed by the
1521 division.

1522 (8) If the division needs to expedite the fifteen-day
1523 legislative notice set forth in paragraph (2) of this subsection
1524 (D), the division shall notify both chairmen.

1525 (E) Notwithstanding any provision of this article, no new
1526 groups or categories of recipients and new types of care and
1527 services may be added without enabling legislation from the
1528 Mississippi Legislature, except that the division may authorize
1529 those changes without enabling legislation when the addition of
1530 recipients or services is ordered by a court of proper authority.



1531 (F) The executive director shall keep the Governor advised
1532 on a timely basis of the funds available for expenditure and the
1533 projected expenditures. Notwithstanding any other provisions of
1534 this article, if current or projected expenditures of the division
1535 are reasonably anticipated to exceed the amount of funds
1536 appropriated to the division for any fiscal year, the Governor,
1537 after consultation with the executive director, shall take all
1538 appropriate measures to reduce costs, which may include, but are
1539 not limited to:

1540 (1) Reducing or discontinuing any or all services that
1541 are deemed to be optional under Title XIX of the Social Security
1542 Act;

1543 (2) Reducing reimbursement rates for any or all service
1544 types;

1545 (3) Imposing additional assessments on health care
1546 providers; or

1547 (4) Any additional cost-containment measures deemed
1548 appropriate by the Governor.

1549 To the extent allowed under federal law, any reduction to
1550 services or reimbursement rates under this subsection (F) shall be
1551 accompanied by a reduction, to the fullest allowable amount, to
1552 the profit margin and administrative fee portions of capitated
1553 payments to organizations described in paragraph (1) of subsection
1554 (H).



1555 Beginning in fiscal year 2010 and in fiscal years thereafter,
1556 when Medicaid expenditures are projected to exceed funds available
1557 for the fiscal year, the division shall submit the expected
1558 shortfall information to the PEER Committee not later than
1559 December 1 of the year in which the shortfall is projected to
1560 occur. PEER shall review the computations of the division and
1561 report its findings to the Legislative Budget Office not later
1562 than January 7 in any year.

1563 (G) Notwithstanding any other provision of this article, it
1564 shall be the duty of each provider participating in the Medicaid
1565 program to keep and maintain books, documents and other records as
1566 prescribed by the Division of Medicaid in accordance with federal
1567 laws and regulations.

1568 (H) (1) Notwithstanding any other provision of this
1569 article, the division is authorized to implement (a) a managed
1570 care program, (b) a coordinated care program, (c) a coordinated
1571 care organization program, (d) a health maintenance organization
1572 program, (e) a patient-centered medical home program, (f) an
1573 accountable care organization program, (g) provider-sponsored
1574 health plan, or (h) any combination of the above programs. As a
1575 condition for the approval of any program under this subsection
1576 (H) (1), the division shall require that no managed care program,
1577 coordinated care program, coordinated care organization program,
1578 health maintenance organization program, or provider-sponsored
1579 health plan may:



1580 (a) Pay providers at a rate that is less than the
1581 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG)
1582 reimbursement rate;

1583 (b) Override the medical decisions of hospital
1584 physicians or staff regarding patients admitted to a hospital for
1585 an emergency medical condition as defined by 42 US Code Section
1586 1395dd. This restriction (b) does not prohibit the retrospective
1587 review of the appropriateness of the determination that an
1588 emergency medical condition exists by chart review or coding
1589 algorithm, nor does it prohibit prior authorization for
1590 nonemergency hospital admissions;

1591 (c) Pay providers at a rate that is less than the
1592 normal Medicaid reimbursement rate. It is the intent of the
1593 Legislature that all managed care entities described in this
1594 subsection (H), in collaboration with the division, develop and
1595 implement innovative payment models that incentivize improvements
1596 in health care quality, outcomes, or value, as determined by the
1597 division. Participation in the provider network of any managed
1598 care, coordinated care, provider-sponsored health plan, or similar
1599 contractor shall not be conditioned on the provider's agreement to
1600 accept such alternative payment models;

1601 (d) Implement a prior authorization and
1602 utilization review program for medical services, transportation
1603 services and prescription drugs that is more stringent than the
1604 prior authorization processes used by the division in its



1605 administration of the Medicaid program. Not later than December
1606 2, 2021, the contractors that are receiving capitated payments
1607 under a managed care delivery system established under this
1608 subsection (H) shall submit a report to the Chairmen of the House
1609 and Senate Medicaid Committees on the status of the prior
1610 authorization and utilization review program for medical services,
1611 transportation services and prescription drugs that is required to
1612 be implemented under this subparagraph (d);

1613 (e) [Deleted]

1614 (f) Implement a preferred drug list that is more
1615 stringent than the mandatory preferred drug list established by
1616 the division under subsection (A) (9) of this section;

1617 (g) Implement a policy which denies beneficiaries
1618 with hemophilia access to the federally funded hemophilia
1619 treatment centers as part of the Medicaid Managed Care network of
1620 providers.

1621 Each health maintenance organization, coordinated care
1622 organization, provider-sponsored health plan, or other
1623 organization paid for services on a capitated basis by the
1624 division under any managed care program or coordinated care
1625 program implemented by the division under this section shall use a
1626 clear set of level of care guidelines in the determination of
1627 medical necessity and in all utilization management practices,
1628 including the prior authorization process, concurrent reviews,
1629 retrospective reviews and payments, that are consistent with



1630 widely accepted professional standards of care. Organizations
1631 participating in a managed care program or coordinated care
1632 program implemented by the division may not use any additional
1633 criteria that would result in denial of care that would be
1634 determined appropriate and, therefore, medically necessary under
1635 those levels of care guidelines.

1636 (2) Notwithstanding any provision of this section, the
1637 recipients eligible for enrollment into a Medicaid Managed Care
1638 Program authorized under this subsection (H) may include only
1639 those categories of recipients eligible for participation in the
1640 Medicaid Managed Care Program as of January 1, 2021, the
1641 Children's Health Insurance Program (CHIP), and the CMS-approved
1642 Section 1115 demonstration waivers in operation as of January 1,
1643 2021. No expansion of Medicaid Managed Care Program contracts may
1644 be implemented by the division without enabling legislation from
1645 the Mississippi Legislature.

1646 (3) (a) Any contractors receiving capitated payments
1647 under a managed care delivery system established in this section
1648 shall provide to the Legislature and the division statistical data
1649 to be shared with provider groups in order to improve patient
1650 access, appropriate utilization, cost savings and health outcomes
1651 not later than October 1 of each year. Additionally, each
1652 contractor shall disclose to the Chairmen of the Senate and House
1653 Medicaid Committees the administrative expenses costs for the
1654 prior calendar year, and the number of full-equivalent employees



1655 located in the State of Mississippi dedicated to the Medicaid and
1656 CHIP lines of business as of June 30 of the current year.

1657 (b) The division and the contractors participating
1658 in the managed care program, a coordinated care program or a
1659 provider-sponsored health plan shall be subject to annual program
1660 reviews or audits performed by the Office of the State Auditor,
1661 the PEER Committee, the Department of Insurance and/or independent
1662 third parties.

1663 (c) Those reviews shall include, but not be
1664 limited to, at least two (2) of the following items:

1665 (i) The financial benefit to the State of
1666 Mississippi of the managed care program,

1667 (ii) The difference between the premiums paid
1668 to the managed care contractors and the payments made by those
1669 contractors to health care providers,

1670 (iii) Compliance with performance measures
1671 required under the contracts,

1672 (iv) Administrative expense allocation
1673 methodologies,

1674 (v) Whether nonprovider payments assigned as
1675 medical expenses are appropriate,

1676 (vi) Capitated arrangements with related
1677 party subcontractors,

1678 (vii) Reasonableness of corporate
1679 allocations,



1680 (viii) Value-added benefits and the extent to
1681 which they are used,
1682 (ix) The effectiveness of subcontractor
1683 oversight, including subcontractor review,
1684 (x) Whether health care outcomes have been
1685 improved, and
1686 (xi) The most common claim denial codes to
1687 determine the reasons for the denials.

1688 The audit reports shall be considered public documents and
1689 shall be posted in their entirety on the division's website.

1690 (4) All health maintenance organizations, coordinated
1691 care organizations, provider-sponsored health plans, or other
1692 organizations paid for services on a capitated basis by the
1693 division under any managed care program or coordinated care
1694 program implemented by the division under this section shall
1695 reimburse all providers in those organizations at rates no lower
1696 than those provided under this section for beneficiaries who are
1697 not participating in those programs.

1698 (5) No health maintenance organization, coordinated
1699 care organization, provider-sponsored health plan, or other
1700 organization paid for services on a capitated basis by the
1701 division under any managed care program or coordinated care
1702 program implemented by the division under this section shall
1703 require its providers or beneficiaries to use any pharmacy that



1704 ships, mails or delivers prescription drugs or legend drugs or
1705 devices.

1706 (6) (a) Not later than December 1, 2021, the
1707 contractors who are receiving capitated payments under a managed
1708 care delivery system established under this subsection (H) shall
1709 develop and implement a uniform credentialing process for
1710 providers. Under that uniform credentialing process, a provider
1711 who meets the criteria for credentialing will be credentialed with
1712 all of those contractors and no such provider will have to be
1713 separately credentialed by any individual contractor in order to
1714 receive reimbursement from the contractor. Not later than
1715 December 2, 2021, those contractors shall submit a report to the
1716 Chairmen of the House and Senate Medicaid Committees on the status
1717 of the uniform credentialing process for providers that is
1718 required under this subparagraph (a).

1719 (b) If those contractors have not implemented a
1720 uniform credentialing process as described in subparagraph (a) by
1721 December 1, 2021, the division shall develop and implement, not
1722 later than July 1, 2022, a single, consolidated credentialing
1723 process by which all providers will be credentialed. Under the
1724 division's single, consolidated credentialing process, no such
1725 contractor shall require its providers to be separately
1726 credentialed by the contractor in order to receive reimbursement
1727 from the contractor, but those contractors shall recognize the



1728 credentialing of the providers by the division's credentialing
1729 process.

1730 (c) The division shall require a uniform provider
1731 credentialing application that shall be used in the credentialing
1732 process that is established under subparagraph (a) or (b). If the
1733 contractor or division, as applicable, has not approved or denied
1734 the provider credentialing application within sixty (60) days of
1735 receipt of the completed application that includes all required
1736 information necessary for credentialing, then the contractor or
1737 division, upon receipt of a written request from the applicant and
1738 within five (5) business days of its receipt, shall issue a
1739 temporary provider credential/enrollment to the applicant if the
1740 applicant has a valid Mississippi professional or occupational
1741 license to provide the health care services to which the
1742 credential/enrollment would apply. The contractor or the division
1743 shall not issue a temporary credential/enrollment if the applicant
1744 has reported on the application a history of medical or other
1745 professional or occupational malpractice claims, a history of
1746 substance abuse or mental health issues, a criminal record, or a
1747 history of medical or other licensing board, state or federal
1748 disciplinary action, including any suspension from participation
1749 in a federal or state program. The temporary
1750 credential/enrollment shall be effective upon issuance and shall
1751 remain in effect until the provider's credentialing/enrollment
1752 application is approved or denied by the contractor or division.



1753 The contractor or division shall render a final decision regarding
1754 credentialing/enrollment of the provider within sixty (60) days
1755 from the date that the temporary provider credential/enrollment is
1756 issued to the applicant.

1757 (d) If the contractor or division does not render
1758 a final decision regarding credentialing/enrollment of the
1759 provider within the time required in subparagraph (c), the
1760 provider shall be deemed to be credentialed by and enrolled with
1761 all of the contractors and eligible to receive reimbursement from
1762 the contractors.

1763 (7) (a) Each contractor that is receiving capitated
1764 payments under a managed care delivery system established under
1765 this subsection (H) shall provide to each provider for whom the
1766 contractor has denied the coverage of a procedure that was ordered
1767 or requested by the provider for or on behalf of a patient, a
1768 letter that provides a detailed explanation of the reasons for the
1769 denial of coverage of the procedure and the name and the
1770 credentials of the person who denied the coverage. The letter
1771 shall be sent to the provider in electronic format.

1772 (b) After a contractor that is receiving capitated
1773 payments under a managed care delivery system established under
1774 this subsection (H) has denied coverage for a claim submitted by a
1775 provider, the contractor shall issue to the provider within sixty
1776 (60) days a final ruling of denial of the claim that allows the
1777 provider to have a state fair hearing and/or agency appeal with



1778 the division. If a contractor does not issue a final ruling of
1779 denial within sixty (60) days as required by this subparagraph
1780 (b), the provider's claim shall be deemed to be automatically
1781 approved and the contractor shall pay the amount of the claim to
1782 the provider.

1783 (c) After a contractor has issued a final ruling
1784 of denial of a claim submitted by a provider, the division shall
1785 conduct a state fair hearing and/or agency appeal on the matter of
1786 the disputed claim between the contractor and the provider within
1787 sixty (60) days, and shall render a decision on the matter within
1788 thirty (30) days after the date of the hearing and/or appeal.

1789 (8) It is the intention of the Legislature that the
1790 division evaluate the feasibility of using a single vendor to
1791 administer pharmacy benefits provided under a managed care
1792 delivery system established under this subsection (H). Providers
1793 of pharmacy benefits shall cooperate with the division in any
1794 transition to a carve-out of pharmacy benefits under managed care.

1795 (9) The division shall evaluate the feasibility of
1796 using a single vendor to administer dental benefits provided under
1797 a managed care delivery system established in this subsection (H).
1798 Providers of dental benefits shall cooperate with the division in
1799 any transition to a carve-out of dental benefits under managed
1800 care.

1801 (10) It is the intent of the Legislature that any
1802 contractor receiving capitated payments under a managed care



1803 delivery system established in this section shall implement
1804 innovative programs to improve the health and well-being of
1805 members diagnosed with prediabetes and diabetes.

1806 (11) It is the intent of the Legislature that any
1807 contractors receiving capitated payments under a managed care
1808 delivery system established under this subsection (H) shall work
1809 with providers of Medicaid services to improve the utilization of
1810 long-acting reversible contraceptives (LARCs). Not later than
1811 December 1, 2021, any contractors receiving capitated payments
1812 under a managed care delivery system established under this
1813 subsection (H) shall provide to the Chairmen of the House and
1814 Senate Medicaid Committees and House and Senate Public Health
1815 Committees a report of LARC utilization for State Fiscal Years
1816 2018 through 2020 as well as any programs, initiatives, or efforts
1817 made by the contractors and providers to increase LARC
1818 utilization. This report shall be updated annually to include
1819 information for subsequent state fiscal years.

1820 (12) The division is authorized to make not more than
1821 one (1) emergency extension of the contracts that are in effect on
1822 July 1, 2021, with contractors who are receiving capitated
1823 payments under a managed care delivery system established under
1824 this subsection (H), as provided in this paragraph (12). The
1825 maximum period of any such extension shall be one (1) year, and
1826 under any such extensions, the contractors shall be subject to all
1827 of the provisions of this subsection (H). The extended contracts



1828 shall be revised to incorporate any provisions of this subsection
1829 (H).

1830 (I) [Deleted]

1831 (J) There shall be no cuts in inpatient and outpatient
1832 hospital payments, or allowable days or volumes, as long as the
1833 hospital assessment provided in Section 43-13-145 is in effect.
1834 This subsection (J) shall not apply to decreases in payments that
1835 are a result of: reduced hospital admissions, audits or payments
1836 under the APR-DRG or APC models, or a managed care program or
1837 similar model described in subsection (H) of this section.

1838 (K) In the negotiation and execution of such contracts
1839 involving services performed by actuarial firms, the Executive
1840 Director of the Division of Medicaid may negotiate a limitation on
1841 liability to the state of prospective contractors.

1842 (L) The Division of Medicaid shall reimburse for services
1843 provided to eligible Medicaid beneficiaries by a licensed birthing
1844 center in a method and manner to be determined by the division in
1845 accordance with federal laws and federal regulations. The
1846 division shall seek any necessary waivers, make any required
1847 amendments to its State Plan or revise any contracts authorized
1848 under subsection (H) of this section as necessary to provide the
1849 services authorized under this subsection. As used in this
1850 subsection, the term "birthing centers" shall have the meaning as
1851 defined in Section 41-77-1(a), which is a publicly or privately
1852 owned facility, place or institution constructed, renovated,



1853 leased or otherwise established where nonemergency births are
1854 planned to occur away from the mother's usual residence following
1855 a documented period of prenatal care for a normal uncomplicated
1856 pregnancy which has been determined to be low risk through a
1857 formal risk-scoring examination.

1858 (M) The Division of Medicaid shall reimburse ambulance
1859 service providers that provide an assessment, triage or treatment
1860 for eligible Medicaid beneficiaries. The reimbursement rate for
1861 an ambulance service provider whose operators provide an
1862 assessment, triage or treatment shall be reimbursed at a rate or
1863 methodology as determined by the division. The division shall
1864 consult with the Mississippi Ambulance Alliance in determining the
1865 initial rate or methodology, and the division shall give due
1866 consideration of the inclusion in the Transforming Reimbursement
1867 for Emergency Ambulance Transportation program.

1868 (* * *~~MN~~) This section shall stand repealed on July
1869 1, * * *~~2028~~ 2029.

1870 **SECTION 3.** Section 43-13-121, Mississippi Code of 1972, is
1871 amended as follows:

1872 43-13-121. (1) The division shall administer the Medicaid
1873 program under the provisions of this article, and may do the
1874 following:

1875 (a) Adopt and promulgate reasonable rules, regulations
1876 and standards, with approval of the Governor, and in accordance



1877 with the Administrative Procedures Law, Section 25-43-1.101 et
1878 seq.:

1879 (i) Establishing methods and procedures as may be
1880 necessary for the proper and efficient administration of this
1881 article;

1882 (ii) Providing Medicaid to all qualified
1883 recipients under the provisions of this article as the division
1884 may determine and within the limits of appropriated funds;

1885 (iii) Establishing reasonable fees, charges and
1886 rates for medical services and drugs; in doing so, the division
1887 shall fix all of those fees, charges and rates at the minimum
1888 levels absolutely necessary to provide the medical assistance
1889 authorized by this article, and shall not change any of those
1890 fees, charges or rates except as may be authorized in Section
1891 43-13-117;

1892 (iv) Providing for fair and impartial hearings;

1893 (v) Providing safeguards for preserving the
1894 confidentiality of records; and

1895 (vi) For detecting and processing fraudulent
1896 practices and abuses of the program;

1897 (b) Receive and expend state, federal and other funds
1898 in accordance with court judgments or settlements and agreements
1899 between the State of Mississippi and the federal government, the
1900 rules and regulations promulgated by the division, with the
1901 approval of the Governor, and within the limitations and



1902 restrictions of this article and within the limits of funds
1903 available for that purpose;

1904 (c) Subject to the limits imposed by this article and
1905 subject to the provisions of subsection (8) of this section, to
1906 submit a Medicaid plan to the United States Department of Health
1907 and Human Services for approval under the provisions of the
1908 federal Social Security Act, to act for the state in making
1909 negotiations relative to the submission and approval of that plan,
1910 to make such arrangements, not inconsistent with the law, as may
1911 be required by or under federal law to obtain and retain that
1912 approval and to secure for the state the benefits of the
1913 provisions of that law.

1914 No agreements, specifically including the general plan for
1915 the operation of the Medicaid program in this state, shall be made
1916 by and between the division and the United States Department of
1917 Health and Human Services unless the Attorney General of the State
1918 of Mississippi has reviewed the agreements, specifically including
1919 the operational plan, and has certified in writing to the Governor
1920 and to the executive director of the division that the agreements,
1921 including the plan of operation, have been drawn strictly in
1922 accordance with the terms and requirements of this article;

1923 (d) In accordance with the purposes and intent of this
1924 article and in compliance with its provisions, provide for aged
1925 persons otherwise eligible for the benefits provided under Title



1926 XVIII of the federal Social Security Act by expenditure of funds
1927 available for those purposes;

1928 (e) To make reports to the United States Department of
1929 Health and Human Services as from time to time may be required by
1930 that federal department and to the Mississippi Legislature as
1931 provided in this section;

1932 (f) Define and determine the scope, duration and amount
1933 of Medicaid that may be provided in accordance with this article
1934 and establish priorities therefor in conformity with this article;

1935 (g) Cooperate and contract with other state agencies
1936 for the purpose of coordinating Medicaid provided under this
1937 article and eliminating duplication and inefficiency in the
1938 Medicaid program;

1939 (h) Adopt and use an official seal of the division;

1940 (i) Sue in its own name on behalf of the State of
1941 Mississippi and employ legal counsel on a contingency basis with
1942 the approval of the Attorney General;

1943 (j) To recover any and all payments incorrectly made by
1944 the division to a recipient or provider from the recipient or
1945 provider receiving the payments. The division shall be authorized
1946 to collect any overpayments to providers sixty (60) days after the
1947 conclusion of any administrative appeal unless the matter is
1948 appealed to a court of proper jurisdiction and bond is posted.
1949 Any appeal filed after July 1, 2015, shall be to the Chancery
1950 Court of the First Judicial District of Hinds County, Mississippi,



1951 within sixty (60) days after the date that the division has
1952 notified the provider by certified mail sent to the proper address
1953 of the provider on file with the division and the provider has
1954 signed for the certified mail notice, or sixty (60) days after the
1955 date of the final decision if the provider does not sign for the
1956 certified mail notice. To recover those payments, the division
1957 may use the following methods, in addition to any other methods
1958 available to the division:

1959 (i) The division shall report to the Department of
1960 Revenue the name of any current or former Medicaid recipient who
1961 has received medical services rendered during a period of
1962 established Medicaid ineligibility and who has not reimbursed the
1963 division for the related medical service payment(s). The
1964 Department of Revenue shall withhold from the state tax refund of
1965 the individual, and pay to the division, the amount of the
1966 payment(s) for medical services rendered to the ineligible
1967 individual that have not been reimbursed to the division for the
1968 related medical service payment(s).

1969 (ii) The division shall report to the Department
1970 of Revenue the name of any Medicaid provider to whom payments were
1971 incorrectly made that the division has not been able to recover by
1972 other methods available to the division. The Department of
1973 Revenue shall withhold from the state tax refund of the provider,
1974 and pay to the division, the amount of the payments that were



1975 incorrectly made to the provider that have not been recovered by
1976 other available methods;

1977 (k) To recover any and all payments by the division
1978 fraudulently obtained by a recipient or provider. Additionally,
1979 if recovery of any payments fraudulently obtained by a recipient
1980 or provider is made in any court, then, upon motion of the
1981 Governor, the judge of the court may award twice the payments
1982 recovered as damages;

1983 (l) Have full, complete and plenary power and authority
1984 to conduct such investigations as it may deem necessary and
1985 requisite of alleged or suspected violations or abuses of the
1986 provisions of this article or of the regulations adopted under
1987 this article, including, but not limited to, fraudulent or
1988 unlawful act or deed by applicants for Medicaid or other benefits,
1989 or payments made to any person, firm or corporation under the
1990 terms, conditions and authority of this article, to suspend or
1991 disqualify any provider of services, applicant or recipient for
1992 gross abuse, fraudulent or unlawful acts for such periods,
1993 including permanently, and under such conditions as the division
1994 deems proper and just, including the imposition of a legal rate of
1995 interest on the amount improperly or incorrectly paid. Recipients
1996 who are found to have misused or abused Medicaid benefits may be
1997 locked into one (1) physician and/or one (1) pharmacy of the
1998 recipient's choice for a reasonable amount of time in order to
1999 educate and promote appropriate use of medical services, in



2000 accordance with federal regulations. If an administrative hearing
2001 becomes necessary, the division may, if the provider does not
2002 succeed in his or her defense, tax the costs of the administrative
2003 hearing, including the costs of the court reporter or stenographer
2004 and transcript, to the provider. The convictions of a recipient
2005 or a provider in a state or federal court for abuse, fraudulent or
2006 unlawful acts under this chapter shall constitute an automatic
2007 disqualification of the recipient or automatic disqualification of
2008 the provider from participation under the Medicaid program.

2009 A conviction, for the purposes of this chapter, shall include
2010 a judgment entered on a plea of nolo contendere or a
2011 nonadjudicated guilty plea and shall have the same force as a
2012 judgment entered pursuant to a guilty plea or a conviction
2013 following trial. A certified copy of the judgment of the court of
2014 competent jurisdiction of the conviction shall constitute prima
2015 facie evidence of the conviction for disqualification purposes;

2016 (m) Establish and provide such methods of
2017 administration as may be necessary for the proper and efficient
2018 operation of the Medicaid program, fully utilizing computer
2019 equipment as may be necessary to oversee and control all current
2020 expenditures for purposes of this article, and to closely monitor
2021 and supervise all recipient payments and vendors rendering
2022 services under this article. Notwithstanding any other provision
2023 of state law, the division is authorized to enter into a ten-year
2024 contract(s) with a vendor(s) to provide services described in this



2025 paragraph (m). Notwithstanding any provision of law to the
2026 contrary, the division is authorized to extend its Medicaid * * *
2027 ~~Management Information Enterprise System * * *, including all~~
2028 ~~related components and services, and Decision Support System and~~
2029 fiscal agent services, including all related components and
2030 services, contracts in effect on June 30, * * * ~~2020~~ 2025,
2031 for * * * ~~a period not to exceed two (2) years without complying~~
2032 ~~with state procurement regulations~~ additional five-year periods if
2033 the system continues to meet the needs of the state, the annual
2034 cost continues to be a fair market value, and the rate of increase
2035 is no more than five percent (5%) or the current Consumer Price
2036 Index, whichever is less. Notwithstanding any other provision of
2037 state law, the division is authorized to enter into a two-year
2038 contract ending no later than June 30, 2027, with a vendor to
2039 provide support of the division's eligibility system;

2040 (n) To cooperate and contract with the federal
2041 government for the purpose of providing Medicaid to Vietnamese and
2042 Cambodian refugees, under the provisions of Public Law 94-23 and
2043 Public Law 94-24, including any amendments to those laws, only to
2044 the extent that the Medicaid assistance and the administrative
2045 cost related thereto are one hundred percent (100%) reimbursable
2046 by the federal government. For the purposes of Section 43-13-117,
2047 persons receiving Medicaid under Public Law 94-23 and Public Law
2048 94-24, including any amendments to those laws, shall not be
2049 considered a new group or category of recipient; and



2050 (o) The division shall impose penalties upon Medicaid
2051 only, Title XIX participating long-term care facilities found to
2052 be in noncompliance with division and certification standards in
2053 accordance with federal and state regulations, including interest
2054 at the same rate calculated by the United States Department of
2055 Health and Human Services and/or the Centers for Medicare and
2056 Medicaid Services (CMS) under federal regulations.

2057 (2) The division also shall exercise such additional powers
2058 and perform such other duties as may be conferred upon the
2059 division by act of the Legislature.

2060 (3) The division, and the State Department of Health as the
2061 agency for licensure of health care facilities and certification
2062 and inspection for the Medicaid and/or Medicare programs, shall
2063 contract for or otherwise provide for the consolidation of on-site
2064 inspections of health care facilities that are necessitated by the
2065 respective programs and functions of the division and the
2066 department.

2067 (4) The division and its hearing officers shall have power
2068 to preserve and enforce order during hearings; to issue subpoenas
2069 for, to administer oaths to and to compel the attendance and
2070 testimony of witnesses, or the production of books, papers,
2071 documents and other evidence, or the taking of depositions before
2072 any designated individual competent to administer oaths; to
2073 examine witnesses; and to do all things conformable to law that
2074 may be necessary to enable them effectively to discharge the



2075 duties of their office. In compelling the attendance and
2076 testimony of witnesses, or the production of books, papers,
2077 documents and other evidence, or the taking of depositions, as
2078 authorized by this section, the division or its hearing officers
2079 may designate an individual employed by the division or some other
2080 suitable person to execute and return that process, whose action
2081 in executing and returning that process shall be as lawful as if
2082 done by the sheriff or some other proper officer authorized to
2083 execute and return process in the county where the witness may
2084 reside. In carrying out the investigatory powers under the
2085 provisions of this article, the executive director or other
2086 designated person or persons may examine, obtain, copy or
2087 reproduce the books, papers, documents, medical charts,
2088 prescriptions and other records relating to medical care and
2089 services furnished by the provider to a recipient or designated
2090 recipients of Medicaid services under investigation. In the
2091 absence of the voluntary submission of the books, papers,
2092 documents, medical charts, prescriptions and other records, the
2093 Governor, the executive director, or other designated person may
2094 issue and serve subpoenas instantly upon the provider, his or her
2095 agent, servant or employee for the production of the books,
2096 papers, documents, medical charts, prescriptions or other records
2097 during an audit or investigation of the provider. If any provider
2098 or his or her agent, servant or employee refuses to produce the
2099 records after being duly subpoenaed, the executive director may



2100 certify those facts and institute contempt proceedings in the
2101 manner, time and place as authorized by law for administrative
2102 proceedings. As an additional remedy, the division may recover
2103 all amounts paid to the provider covering the period of the audit
2104 or investigation, inclusive of a legal rate of interest and a
2105 reasonable attorney's fee and costs of court if suit becomes
2106 necessary. Division staff shall have immediate access to the
2107 provider's physical location, facilities, records, documents,
2108 books, and any other records relating to medical care and services
2109 rendered to recipients during regular business hours.

2110 (5) If any person in proceedings before the division
2111 disobeys or resists any lawful order or process, or misbehaves
2112 during a hearing or so near the place thereof as to obstruct the
2113 hearing, or neglects to produce, after having been ordered to do
2114 so, any pertinent book, paper or document, or refuses to appear
2115 after having been subpoenaed, or upon appearing refuses to take
2116 the oath as a witness, or after having taken the oath refuses to
2117 be examined according to law, the executive director shall certify
2118 the facts to any court having jurisdiction in the place in which
2119 it is sitting, and the court shall thereupon, in a summary manner,
2120 hear the evidence as to the acts complained of, and if the
2121 evidence so warrants, punish that person in the same manner and to
2122 the same extent as for a contempt committed before the court, or
2123 commit that person upon the same condition as if the doing of the



2124 forbidden act had occurred with reference to the process of, or in
2125 the presence of, the court.

2126 (6) In suspending or terminating any provider from
2127 participation in the Medicaid program, the division shall preclude
2128 the provider from submitting claims for payment, either personally
2129 or through any clinic, group, corporation or other association to
2130 the division or its fiscal agents for any services or supplies
2131 provided under the Medicaid program except for those services or
2132 supplies provided before the suspension or termination. No
2133 clinic, group, corporation or other association that is a provider
2134 of services shall submit claims for payment to the division or its
2135 fiscal agents for any services or supplies provided by a person
2136 within that organization who has been suspended or terminated from
2137 participation in the Medicaid program except for those services or
2138 supplies provided before the suspension or termination. When this
2139 provision is violated by a provider of services that is a clinic,
2140 group, corporation or other association, the division may suspend
2141 or terminate that organization from participation. Suspension may
2142 be applied by the division to all known affiliates of a provider,
2143 provided that each decision to include an affiliate is made on a
2144 case-by-case basis after giving due regard to all relevant facts
2145 and circumstances. The violation, failure or inadequacy of
2146 performance may be imputed to a person with whom the provider is
2147 affiliated where that conduct was accomplished within the course



2148 of his or her official duty or was effectuated by him or her with
2149 the knowledge or approval of that person.

2150 (7) The division may deny or revoke enrollment in the
2151 Medicaid program to a provider if any of the following are found
2152 to be applicable to the provider, his or her agent, a managing
2153 employee or any person having an ownership interest equal to five
2154 percent (5%) or greater in the provider:

2155 (a) Failure to truthfully or fully disclose any and all
2156 information required, or the concealment of any and all
2157 information required, on a claim, a provider application or a
2158 provider agreement, or the making of a false or misleading
2159 statement to the division relative to the Medicaid program.

2160 (b) Previous or current exclusion, suspension,
2161 termination from or the involuntary withdrawing from participation
2162 in the Medicaid program, any other state's Medicaid program,
2163 Medicare or any other public or private health or health insurance
2164 program. If the division ascertains that a provider has been
2165 convicted of a felony under federal or state law for an offense
2166 that the division determines is detrimental to the best interest
2167 of the program or of Medicaid beneficiaries, the division may
2168 refuse to enter into an agreement with that provider, or may
2169 terminate or refuse to renew an existing agreement.

2170 (c) Conviction under federal or state law of a criminal
2171 offense relating to the delivery of any goods, services or
2172 supplies, including the performance of management or



2173 administrative services relating to the delivery of the goods,
2174 services or supplies, under the Medicaid program, any other
2175 state's Medicaid program, Medicare or any other public or private
2176 health or health insurance program.

2177 (d) Conviction under federal or state law of a criminal
2178 offense relating to the neglect or abuse of a patient in
2179 connection with the delivery of any goods, services or supplies.

2180 (e) Conviction under federal or state law of a criminal
2181 offense relating to the unlawful manufacture, distribution,
2182 prescription or dispensing of a controlled substance.

2183 (f) Conviction under federal or state law of a criminal
2184 offense relating to fraud, theft, embezzlement, breach of
2185 fiduciary responsibility or other financial misconduct.

2186 (g) Conviction under federal or state law of a criminal
2187 offense punishable by imprisonment of a year or more that involves
2188 moral turpitude, or acts against the elderly, children or infirm.

2189 (h) Conviction under federal or state law of a criminal
2190 offense in connection with the interference or obstruction of any
2191 investigation into any criminal offense listed in paragraphs (c)
2192 through (i) of this subsection.

2193 (i) Sanction for a violation of federal or state laws
2194 or rules relative to the Medicaid program, any other state's
2195 Medicaid program, Medicare or any other public health care or
2196 health insurance program.

2197 (j) Revocation of license or certification.



2198 (k) Failure to pay recovery properly assessed or
2199 pursuant to an approved repayment schedule under the Medicaid
2200 program.

2201 (l) Failure to meet any condition of enrollment.

2202 (8) (a) As used in this subsection (8), the following terms
2203 shall be defined as provided in this paragraph, except as
2204 otherwise provided in this subsection:

2205 (i) "Committees" means the Medicaid Committees of
2206 the House of Representatives and the Senate, and "committee" means
2207 either one of those committees.

2208 (ii) "State Plan" means the agreement between the
2209 State of Mississippi and the federal government regarding the
2210 nature and scope of Mississippi's Medicaid Program.

2211 (iii) "State Plan Amendment" means a change to the
2212 State Plan, which must be approved by the Centers for Medicare and
2213 Medicaid Services (CMS) before its implementation.

2214 (b) Whenever the Division of Medicaid proposes a State
2215 Plan Amendment, the division shall give notice to the chairmen of
2216 the committees at least * * * ~~thirty (30)~~ fifteen (15) calendar
2217 days before the proposed State Plan Amendment is filed with CMS.
2218 The division shall furnish the chairmen with a concise summary of
2219 each proposed State Plan Amendment along with the notice, and
2220 shall furnish the chairmen with a copy of any proposed State Plan
2221 Amendment upon request. The division also shall provide a summary



2222 and copy of any proposed State Plan Amendment to any other member
2223 of the Legislature upon request.

2224 (c) If the chairman of either committee or both
2225 chairmen jointly object to the proposed State Plan Amendment or
2226 any part thereof, the chairman or chairmen shall notify the
2227 division and provide the reasons for their objection in writing
2228 not later than seven (7) calendar days after receipt of the notice
2229 from the division. The chairman or chairmen may make written
2230 recommendations to the division for changes to be made to a
2231 proposed State Plan Amendment.

2232 (d) (i) The chairman of either committee or both
2233 chairmen jointly may hold a committee meeting to review a proposed
2234 State Plan Amendment. If either chairman or both chairmen decide
2235 to hold a meeting, they shall notify the division of their
2236 intention in writing within seven (7) calendar days after receipt
2237 of the notice from the division, and shall set the date and time
2238 for the meeting in their notice to the division, which shall not
2239 be later than fourteen (14) calendar days after receipt of the
2240 notice from the division.

2241 (ii) After the committee meeting, the committee or
2242 committees may object to the proposed State Plan Amendment or any
2243 part thereof. The committee or committees shall notify the
2244 division and the reasons for their objection in writing not later
2245 than seven (7) calendar days after the meeting. The committee or



2246 committees may make written recommendations to the division for
2247 changes to be made to a proposed State Plan Amendment.

2248 (e) If both chairmen notify the division in writing
2249 within seven (7) calendar days after receipt of the notice from
2250 the division that they do not object to the proposed State Plan
2251 Amendment and will not be holding a meeting to review the proposed
2252 State Plan Amendment, the division may proceed to file the
2253 proposed State Plan Amendment with CMS.

2254 (f) (i) If there are any objections to a proposed rate
2255 change or any part thereof from either or both of the chairmen or
2256 the committees, the division may withdraw the proposed State Plan
2257 Amendment, make any of the recommended changes to the proposed
2258 State Plan Amendment, or not make any changes to the proposed
2259 State Plan Amendment.

2260 (ii) If the division does not make any changes to
2261 the proposed State Plan Amendment, it shall notify the chairmen of
2262 that fact in writing, and may proceed to file the State Plan
2263 Amendment with CMS.

2264 (iii) If the division makes any changes to the
2265 proposed State Plan Amendment, the division shall notify the
2266 chairmen of its actions in writing, and may proceed to file the
2267 State Plan Amendment with CMS.

2268 (g) Nothing in this subsection (8) shall be construed
2269 as giving the chairmen or the committees any authority to veto,
2270 nullify or revise any State Plan Amendment proposed by the



2271 division. The authority of the chairmen or the committees under
2272 this subsection shall be limited to reviewing, making objections
2273 to and making recommendations for changes to State Plan Amendments
2274 proposed by the division.

2275 (i) If the division does not make any changes to
2276 the proposed State Plan Amendment, it shall notify the chairmen of
2277 that fact in writing, and may proceed to file the proposed State
2278 Plan Amendment with CMS.

2279 (ii) If the division makes any changes to the
2280 proposed State Plan Amendment, the division shall notify the
2281 chairmen of the changes in writing, and may proceed to file the
2282 proposed State Plan Amendment with CMS.

2283 (iii) If the division needs to expedite the
2284 fifteen-day legislative notice set forth in paragraph (b) of this
2285 subsection (8), the division will notify both chairmen.

2286 (h) Nothing in this subsection (8) shall be construed
2287 as giving the chairmen of the committees any authority to veto,
2288 nullify or revise any State Plan Amendment proposed by the
2289 division. The authority of the chairmen of the committees under
2290 this subsection shall be limited to reviewing, making objections
2291 to and making recommendations for suggested changes to State Plan
2292 Amendments proposed by the division.

2293 **SECTION 4.** Section 43-13-305, Mississippi Code of 1972, is
2294 amended as follows:



2295 43-13-305. (1) By accepting Medicaid from the Division of
2296 Medicaid in the Office of the Governor, the recipient shall, to
2297 the extent of the payment of medical expenses by the Division of
2298 Medicaid, be deemed to have made an assignment to the Division of
2299 Medicaid of any and all rights and interests in any third-party
2300 benefits, hospitalization or indemnity contract or any cause of
2301 action, past, present or future, against any person, firm or
2302 corporation for Medicaid benefits provided to the recipient by the
2303 Division of Medicaid for injuries, disease or sickness caused or
2304 suffered under circumstances creating a cause of action in favor
2305 of the recipient against any such person, firm or corporation as
2306 set out in Section 43-13-125. The recipient shall be deemed,
2307 without the necessity of signing any document, to have appointed
2308 the Division of Medicaid as his or her true and lawful
2309 attorney-in-fact in his or her name, place and stead in collecting
2310 any and all amounts due and owing for medical expenses paid by the
2311 Division of Medicaid against such person, firm or corporation.

2312 (2) Whenever a provider of medical services or the Division
2313 of Medicaid submits claims to an insurer on behalf of a Medicaid
2314 recipient for whom an assignment of rights has been received, or
2315 whose rights have been assigned by the operation of law, the
2316 insurer must respond within sixty (60) days of receipt of a claim
2317 by forwarding payment or issuing a notice of denial directly to
2318 the submitter of the claim. The failure of the insuring entity to
2319 comply with the provisions of this section shall subject the



2320 insuring entity to recourse by the Division of Medicaid in
2321 accordance with the provision of Section 43-13-315. In the case
2322 of a responsible insurer, other than the insurers exempted under
2323 federal law, that requires prior authorization for an item or
2324 service furnished to a recipient, the insurer shall accept
2325 authorization provided by the Division of Medicaid that the item
2326 or service is covered under the state plan (or waiver of such
2327 plan) for such recipient, as if such authorization were the prior
2328 authorization made by the third party for such item or service.

2329 The Division of Medicaid shall be authorized to endorse any and
2330 all, including, but not limited to, multi-payee checks, drafts,
2331 money orders or other negotiable instruments representing Medicaid
2332 payment recoveries that are received by the Division of Medicaid.

2333 (3) Court orders or agreements for medical support shall
2334 direct such payments to the Division of Medicaid, which shall be
2335 authorized to endorse any and all checks, drafts, money orders or
2336 other negotiable instruments representing medical support payments
2337 which are received. Any designated medical support funds received
2338 by the State Department of Human Services or through its local
2339 county departments shall be paid over to the Division of Medicaid.
2340 When medical support for a Medicaid recipient is available through
2341 an absent parent or custodial parent, the insuring entity shall
2342 direct the medical support payment(s) to the provider of medical
2343 services or to the Division of Medicaid.



2344 **SECTION 5.** Section 43-11-1, Mississippi Code of 1972, is
2345 amended as follows:

2346 43-11-1. When used in this chapter, the following words
2347 shall have the following meaning:

2348 (a) "Institutions for the aged or infirm" means a place
2349 either governmental or private that provides group living
2350 arrangements for four (4) or more persons who are unrelated to the
2351 operator and who are being provided food, shelter and personal
2352 care, whether any such place is organized or operated for profit
2353 or not. The term "institution for the aged or infirm" includes
2354 nursing homes, pediatric skilled nursing facilities, psychiatric
2355 residential treatment facilities, convalescent homes, homes for
2356 the aged, adult foster care facilities and special care facilities
2357 for paroled inmates, provided that these institutions fall within
2358 the scope of the definitions set forth above. The term
2359 "institution for the aged or infirm" does not include hospitals,
2360 clinics or mental institutions devoted primarily to providing
2361 medical service, and does not include any private residence in
2362 which the owner of the residence is providing personal care
2363 services to disabled or homeless veterans under an agreement with,
2364 and in compliance with the standards prescribed by, the United
2365 States Department of Veterans Affairs, if the owner of the
2366 residence also provided personal care services to disabled or
2367 homeless veterans at any time during calendar year 2008.



2368 (b) "Person" means any individual, firm, partnership,
2369 corporation, company, association or joint-stock association, or
2370 any licensee herein or the legal successor thereof.

2371 (c) "Personal care" means assistance rendered by
2372 personnel of the home to aged or infirm residents in performing
2373 one or more of the activities of daily living, which includes, but
2374 is not limited to, the bathing, walking, excretory functions,
2375 feeding, personal grooming and dressing of such residents.

2376 (d) "Psychiatric residential treatment facility" means
2377 any nonhospital establishment with permanent facilities which
2378 provides a twenty-four-hour program of care by qualified
2379 therapists, including, but not limited to, duly licensed mental
2380 health professionals, psychiatrists, psychologists,
2381 psychotherapists and licensed certified social workers, for
2382 emotionally disturbed children and adolescents referred to such
2383 facility by a court, local school district or by the Department of
2384 Human Services, who are not in an acute phase of illness requiring
2385 the services of a psychiatric hospital, and are in need of such
2386 restorative treatment services. For purposes of this paragraph,
2387 the term "emotionally disturbed" means a condition exhibiting one
2388 or more of the following characteristics over a long period of
2389 time and to a marked degree, which adversely affects educational
2390 performance:

2391 1. An inability to learn which cannot be explained
2392 by intellectual, sensory or health factors;



2393 2. An inability to build or maintain satisfactory
2394 relationships with peers and teachers;

2395 3. Inappropriate types of behavior or feelings
2396 under normal circumstances;

2397 4. A general pervasive mood of unhappiness or
2398 depression; or

2399 5. A tendency to develop physical symptoms or
2400 fears associated with personal or school problems. An
2401 establishment furnishing primarily domiciliary care is not within
2402 this definition.

2403 (e) "Pediatric skilled nursing facility" means an
2404 institution or a distinct part of an institution that is primarily
2405 engaged in providing to inpatients skilled nursing care and
2406 related services for persons under twenty-one (21) years of age
2407 who require medical or nursing care or rehabilitation services for
2408 the rehabilitation of injured, disabled or sick persons.

2409 (f) "Licensing agency" means the State Department of
2410 Health.

2411 (g) "Medical records" mean, without restriction, those
2412 medical histories, records, reports, summaries, diagnoses and
2413 prognoses, records of treatment and medication ordered and given,
2414 notes, entries, x-rays and other written or graphic data prepared,
2415 kept, made or maintained in institutions for the aged or infirm
2416 that pertain to residency in, or services rendered to residents
2417 of, an institution for the aged or infirm.



2418 (h) "Adult foster care facility" means a home setting
2419 for vulnerable adults in the community who are unable to live
2420 independently due to physical, emotional, developmental or mental
2421 impairments, or in need of emergency and continuing protective
2422 social services for purposes of preventing further abuse or
2423 neglect and for safeguarding and enhancing the welfare of the
2424 abused or neglected vulnerable adult. Adult foster care programs
2425 shall be designed to meet the needs of vulnerable adults with
2426 impairments through individual plans of care, which provide a
2427 variety of health, social and related support services in a
2428 protective setting, enabling participants to live in the
2429 community. Adult foster care programs may be (i) traditional,
2430 where the foster care provider lives in the residence and is the
2431 primary caregiver to clients in the home; (ii) corporate, where
2432 the foster care home is operated by a corporation with shift staff
2433 delivering services to clients; or (iii) shelter, where the foster
2434 care home accepts clients on an emergency short-term basis for up
2435 to thirty (30) days.

2436 (i) "Special care facilities for paroled inmates" means
2437 long-term care and skilled nursing facilities licensed as special
2438 care facilities for medically frail paroled inmates, formed to
2439 ease the burden of prison overcrowding and provide compassionate
2440 release and medical parole initiatives while impacting economic
2441 outcomes for the Mississippi prison system. The facilities shall
2442 meet all Mississippi Department of Health and federal Center for



2443 Medicaid Services (CMS) requirements and shall be regulated by
2444 both agencies; provided, however, such regulations shall not be as
2445 restrictive as those required for personal care homes and other
2446 institutions devoted primarily to providing medical services. The
2447 facilities will offer physical, occupational and speech therapy,
2448 nursing services, wound care, a dedicated COVID services unit,
2449 individualized patient centered plans of care, social services,
2450 spiritual services, physical activities, transportation,
2451 medication, durable medical equipment, personalized meal plans by
2452 a licensed dietician and security services. There may be up to
2453 three (3) facilities located in each Supreme Court district, to be
2454 designated by the Chairman of the State Parole Board or his
2455 designee.

2456 (j) "Adult day care facility" means a public agency or
2457 private organization, or a subdivision of such an agency or
2458 organization, that:

2459 (i) Provides the following items and services:

2460 1. Nursing services;

2461 2. Transportation of the individual to and
2462 from such adult day care facility in connection with any such item
2463 or service;

2464 3. Meals;

2465 4. A program of supervised activities that

2466 meets such criteria as the licensing agency determines and is

2467 appropriately designed to promote physical and mental health that



2468 is furnished to the individual by such a facility in a group
2469 setting for a period not greater than twelve (12) hours per day;

2470 5. The administration of medication by a
2471 licensed nurse, and a medication management program to minimize
2472 unnecessary or inappropriate use of prescription drugs and adverse
2473 events due to unintended prescription drug-to-drug interactions;
2474 and

2475 (ii) Meets such standards established by the
2476 licensing agency to assure quality of care and such other
2477 requirements as the licensing agency finds necessary in the
2478 interest of the health and safety of individuals who are furnished
2479 services in the facility.

2480 **SECTION 6.** Section 43-11-8, Mississippi Code of 1972, is
2481 amended as follows:

2482 43-11-8. (1) An application for a license for an adult
2483 foster care facility or for an adult day care facility shall be
2484 made to the licensing agency upon forms provided by it and shall
2485 contain such information as the licensing agency reasonably
2486 requires, which may include affirmative evidence of ability to
2487 comply with such reasonable standards, rules and regulations as
2488 are lawfully prescribed hereunder. Each application for a license
2489 for an adult foster care facility or for an adult day care
2490 facility shall be accompanied by a license fee of Ten Dollars
2491 (\$10.00) for each person or bed of licensed capacity, with a
2492 minimum fee per home or institution of Fifty Dollars (\$50.00),



2493 which shall be paid to the licensing agency. Any increase in the
2494 fee charged by the licensing agency under this subsection shall be
2495 in accordance with the provisions of Section 41-3-65.

2496 (2) A license, unless suspended or revoked, shall be
2497 renewable annually upon payment by the licensee of an adult foster
2498 care facility or of an adult day care facility, except for
2499 personal care homes, of a renewal fee of Ten Dollars (\$10.00) for
2500 each person or bed of licensed capacity in the institution, with a
2501 minimum renewal fee per institution of Fifty Dollars (\$50.00),
2502 which shall be paid to the licensing agency, and upon filing by
2503 the licensee and approval by the licensing agency of an annual
2504 report upon such uniform dates and containing such information in
2505 such form as the licensing agency prescribes by regulation. Any
2506 increase in the fee charged by the licensing agency under this
2507 subsection shall be in accordance with the provisions of Section
2508 41-3-65. Each license shall be issued only for the premises and
2509 person or persons or other legal entity or entities named in the
2510 application and shall not be transferable or assignable except
2511 with the written approval of the licensing agency. Licenses shall
2512 be posted in a conspicuous place on the licensed premises.

2513 **SECTION 7.** Section 43-11-13, Mississippi Code of 1972, is
2514 amended as follows:

2515 43-11-13. (1) The licensing agency shall adopt, amend,
2516 promulgate and enforce such rules, regulations and standards,
2517 including classifications, with respect to all institutions for



2518 the aged or infirm to be licensed under this chapter as may be
2519 designed to further the accomplishment of the purpose of this
2520 chapter in promoting adequate care of individuals in those
2521 institutions in the interest of public health, safety and welfare.
2522 Those rules, regulations and standards shall be adopted and
2523 promulgated by the licensing agency and shall be recorded and
2524 indexed in a book to be maintained by the licensing agency in its
2525 main office in the State of Mississippi, entitled "Rules,
2526 Regulations and Minimum Standards for Institutions for the Aged or
2527 Infirm" and the book shall be open and available to all
2528 institutions for the aged or infirm and the public generally at
2529 all reasonable times. Upon the adoption of those rules,
2530 regulations and standards, the licensing agency shall mail copies
2531 thereof to all those institutions in the state that have filed
2532 with the agency their names and addresses for this purpose, but
2533 the failure to mail the same or the failure of the institutions to
2534 receive the same shall in no way affect the validity thereof. The
2535 rules, regulations and standards may be amended by the licensing
2536 agency, from time to time, as necessary to promote the health,
2537 safety and welfare of persons living in those institutions.

2538 (2) The licensee shall keep posted in a conspicuous place on
2539 the licensed premises all current rules, regulations and minimum
2540 standards applicable to fire protection measures as adopted by the
2541 licensing agency. The licensee shall furnish to the licensing
2542 agency at least once each six (6) months a certificate of approval



2543 and inspection by state or local fire authorities. Failure to
2544 comply with state laws and/or municipal ordinances and current
2545 rules, regulations and minimum standards as adopted by the
2546 licensing agency, relative to fire prevention measures, shall be
2547 prima facie evidence for revocation of license.

2548 (3) The State Board of Health shall promulgate rules and
2549 regulations restricting the storage, quantity and classes of drugs
2550 allowed in personal care homes and adult foster care facilities.
2551 Residents requiring administration of Schedule II Narcotics as
2552 defined in the Uniform Controlled Substances Law may be admitted
2553 to a personal care home. Schedule drugs may only be allowed in a
2554 personal care home if they are administered or stored utilizing
2555 proper procedures under the direct supervision of a licensed
2556 physician or nurse.

2557 (4) (a) Notwithstanding any determination by the licensing
2558 agency that skilled nursing services would be appropriate for a
2559 resident of a personal care home, that resident, the resident's
2560 guardian or the legally recognized responsible party for the
2561 resident may consent in writing for the resident to continue to
2562 reside in the personal care home, if approved in writing by a
2563 licensed physician. However, no personal care home shall allow
2564 more than two (2) residents, or ten percent (10%) of the total
2565 number of residents in the facility, whichever is greater, to
2566 remain in the personal care home under the provisions of this
2567 subsection (4). This consent shall be deemed to be appropriately



2568 informed consent as described in the regulations promulgated by
2569 the licensing agency. After that written consent has been
2570 obtained, the resident shall have the right to continue to reside
2571 in the personal care home for as long as the resident meets the
2572 other conditions for residing in the personal care home. A copy
2573 of the written consent and the physician's approval shall be
2574 forwarded by the personal care home to the licensing agency.

2575 (b) The State Board of Health shall promulgate rules
2576 and regulations restricting the handling of a resident's personal
2577 deposits by the director of a personal care home. Any funds given
2578 or provided for the purpose of supplying extra comforts,
2579 conveniences or services to any resident in any personal care
2580 home, and any funds otherwise received and held from, for or on
2581 behalf of any such resident, shall be deposited by the director or
2582 other proper officer of the personal care home to the credit of
2583 that resident in an account that shall be known as the Resident's
2584 Personal Deposit Fund. No more than one (1) month's charge for
2585 the care, support, maintenance and medical attention of the
2586 resident shall be applied from the account at any one time. After
2587 the death, discharge or transfer of any resident for whose benefit
2588 any such fund has been provided, any unexpended balance remaining
2589 in his personal deposit fund shall be applied for the payment of
2590 care, cost of support, maintenance and medical attention that is
2591 accrued. If any unexpended balance remains in that resident's
2592 personal deposit fund after complete reimbursement has been made



2593 for payment of care, support, maintenance and medical attention,
2594 and the director or other proper officer of the personal care home
2595 has been or shall be unable to locate the person or persons
2596 entitled to the unexpended balance, the director or other proper
2597 officer may, after the lapse of one (1) year from the date of that
2598 death, discharge or transfer, deposit the unexpended balance to
2599 the credit of the personal care home's operating fund.

2600 (c) The State Board of Health shall promulgate rules
2601 and regulations requiring personal care homes to maintain records
2602 relating to health condition, medicine dispensed and administered,
2603 and any reaction to that medicine. The director of the personal
2604 care home shall be responsible for explaining the availability of
2605 those records to the family of the resident at any time upon
2606 reasonable request.

2607 (5) The State Board of Health and the Mississippi Department
2608 of Corrections shall jointly issue rules and regulations for the
2609 operation of the special care facilities for paroled inmates.

2610 (6) (a) For the purposes of this subsection (6):

2611 (i) "Licensed entity" means a hospital, nursing
2612 home, personal care home, home health agency, hospice or adult
2613 foster care facility;

2614 (ii) "Covered entity" means a licensed entity or a
2615 health care professional staffing agency;

2616 (iii) "Employee" means any individual employed by
2617 a covered entity, and also includes any individual who by contract



2618 provides to the patients, residents or clients being served by the
2619 covered entity direct, hands-on, medical patient care in a
2620 patient's, resident's or client's room or in treatment or recovery
2621 rooms. The term "employee" does not include health care
2622 professional/vocational technical students performing clinical
2623 training in a licensed entity under contracts between their
2624 schools and the licensed entity, and does not include students at
2625 high schools located in Mississippi who observe the treatment and
2626 care of patients in a licensed entity as part of the requirements
2627 of an allied-health course taught in the high school, if:

2628 1. The student is under the supervision of a
2629 licensed health care provider; and

2630 2. The student has signed an affidavit that
2631 is on file at the student's school stating that he or she has not
2632 been convicted of or pleaded guilty or nolo contendere to a felony
2633 listed in paragraph (d) of this subsection (6), or that any such
2634 conviction or plea was reversed on appeal or a pardon was granted
2635 for the conviction or plea. Before any student may sign such an
2636 affidavit, the student's school shall provide information to the
2637 student explaining what a felony is and the nature of the felonies
2638 listed in paragraph (d) of this subsection (6).

2639 However, the health care professional/vocational technical
2640 academic program in which the student is enrolled may require the
2641 student to obtain criminal history record checks. In such
2642 incidences, paragraph (a)(iii)1 and 2 of this subsection (6) does



2643 not preclude the licensing entity from processing submitted
2644 fingerprints of students from healthcare-related
2645 professional/vocational technical programs who, as part of their
2646 program of study, conduct observations and provide clinical care
2647 and services in a covered entity.

2648 (b) Under regulations promulgated by the State Board of
2649 Health, the licensing agency shall require to be performed a
2650 criminal history record check on (i) every new employee of a
2651 covered entity who provides direct patient care or services and
2652 who is employed on or after July 1, 2003, and (ii) every employee
2653 of a covered entity employed before July 1, 2003, who has a
2654 documented disciplinary action by his or her present employer. In
2655 addition, the licensing agency shall require the covered entity to
2656 perform a disciplinary check with the professional licensing
2657 agency of each employee, if any, to determine if any disciplinary
2658 action has been taken against the employee by that agency.

2659 Except as otherwise provided in paragraph (c) of this
2660 subsection (6), no such employee hired on or after July 1, 2003,
2661 shall be permitted to provide direct patient care until the
2662 results of the criminal history record check have revealed no
2663 disqualifying record or the employee has been granted a waiver.
2664 In order to determine the employee applicant's suitability for
2665 employment, the applicant shall be fingerprinted. Fingerprints
2666 shall be submitted to the licensing agency from scanning, with the
2667 results processed through the Department of Public Safety's



2668 Criminal Information Center. The fingerprints shall then be
2669 forwarded by the Department of Public Safety to the Federal Bureau
2670 of Investigation for a national criminal history record check.
2671 The licensing agency shall notify the covered entity of the
2672 results of an employee applicant's criminal history record check.
2673 If the criminal history record check discloses a felony
2674 conviction, guilty plea or plea of nolo contendere to a felony of
2675 possession or sale of drugs, murder, manslaughter, armed robbery,
2676 rape, sexual battery, sex offense listed in Section 45-33-23(h),
2677 child abuse, arson, grand larceny, burglary, gratification of lust
2678 or aggravated assault, or felonious abuse and/or battery of a
2679 vulnerable adult that has not been reversed on appeal or for which
2680 a pardon has not been granted, the employee applicant shall not be
2681 eligible to be employed by the covered entity.

2682 (c) Any such new employee applicant may, however, be
2683 employed on a temporary basis pending the results of the criminal
2684 history record check, but any employment contract with the new
2685 employee shall be voidable if the new employee receives a
2686 disqualifying criminal history record check and no waiver is
2687 granted as provided in this subsection (6).

2688 (d) Under regulations promulgated by the State Board of
2689 Health, the licensing agency shall require every employee of a
2690 covered entity employed before July 1, 2003, to sign an affidavit
2691 stating that he or she has not been convicted of or pleaded guilty
2692 or nolo contendere to a felony of possession or sale of drugs,



2693 murder, manslaughter, armed robbery, rape, sexual battery, any sex
2694 offense listed in Section 45-33-23(h), child abuse, arson, grand
2695 larceny, burglary, gratification of lust, aggravated assault, or
2696 felonious abuse and/or battery of a vulnerable adult, or that any
2697 such conviction or plea was reversed on appeal or a pardon was
2698 granted for the conviction or plea. No such employee of a covered
2699 entity hired before July 1, 2003, shall be permitted to provide
2700 direct patient care until the employee has signed the affidavit
2701 required by this paragraph (d). All such existing employees of
2702 covered entities must sign the affidavit required by this
2703 paragraph (d) within six (6) months of the final adoption of the
2704 regulations promulgated by the State Board of Health. If a person
2705 signs the affidavit required by this paragraph (d), and it is
2706 later determined that the person actually had been convicted of or
2707 pleaded guilty or nolo contendere to any of the offenses listed in
2708 this paragraph (d) and the conviction or plea has not been
2709 reversed on appeal or a pardon has not been granted for the
2710 conviction or plea, the person is guilty of perjury. If the
2711 offense that the person was convicted of or pleaded guilty or nolo
2712 contendere to was a violent offense, the person, upon a conviction
2713 of perjury under this paragraph, shall be punished as provided in
2714 Section 97-9-61. If the offense that the person was convicted of
2715 or pleaded guilty or nolo contendere to was a nonviolent offense,
2716 the person, upon a conviction of perjury under this paragraph,
2717 shall be punished by a fine of not more than Five Hundred Dollars



2718 (\$500.00), or by imprisonment in the county jail for not more than
2719 six (6) months, or by both such fine and imprisonment.

2720 (e) The covered entity may, in its discretion, allow
2721 any employee who is unable to sign the affidavit required by
2722 paragraph (d) of this subsection (6) or any employee applicant
2723 aggrieved by an employment decision under this subsection (6) to
2724 appear before the covered entity's hiring officer, or his or her
2725 designee, to show mitigating circumstances that may exist and
2726 allow the employee or employee applicant to be employed by the
2727 covered entity. The covered entity, upon report and
2728 recommendation of the hiring officer, may grant waivers for those
2729 mitigating circumstances, which shall include, but not be limited
2730 to: (i) age at which the crime was committed; (ii) circumstances
2731 surrounding the crime; (iii) length of time since the conviction
2732 and criminal history since the conviction; (iv) work history; (v)
2733 current employment and character references; and (vi) other
2734 evidence demonstrating the ability of the individual to perform
2735 the employment responsibilities competently and that the
2736 individual does not pose a threat to the health or safety of the
2737 patients of the covered entity.

2738 (f) The licensing agency may charge the covered entity
2739 submitting the fingerprints a fee not to exceed Fifty Dollars
2740 (\$50.00), which covered entity may, in its discretion, charge the
2741 same fee, or a portion thereof, to the employee applicant. Any
2742 increase in the fee charged by the licensing agency under this



2743 paragraph shall be in accordance with the provisions of Section
2744 41-3-65. Any costs incurred by a covered entity implementing this
2745 subsection (6) shall be reimbursed as an allowable cost under
2746 Section 43-13-116.

2747 (g) If the results of an employee applicant's criminal
2748 history record check reveals no disqualifying event, then the
2749 covered entity shall, within two (2) weeks of the notification of
2750 no disqualifying event, provide the employee applicant with a
2751 notarized letter signed by the chief executive officer of the
2752 covered entity, or his or her authorized designee, confirming the
2753 employee applicant's suitability for employment based on his or
2754 her criminal history record check. An employee applicant may use
2755 that letter for a period of two (2) years from the date of the
2756 letter to seek employment with any covered entity without the
2757 necessity of an additional criminal history record check. Any
2758 covered entity presented with the letter may rely on the letter
2759 with respect to an employee applicant's criminal background and is
2760 not required for a period of two (2) years from the date of the
2761 letter to conduct or have conducted a criminal history record
2762 check as required in this subsection (6).

2763 (h) The licensing agency, the covered entity, and their
2764 agents, officers, employees, attorneys and representatives, shall
2765 be presumed to be acting in good faith for any employment decision
2766 or action taken under this subsection (6). The presumption of
2767 good faith may be overcome by a preponderance of the evidence in



2768 any civil action. No licensing agency, covered entity, nor their
2769 agents, officers, employees, attorneys and representatives shall
2770 be held liable in any employment decision or action based in whole
2771 or in part on compliance with or attempts to comply with the
2772 requirements of this subsection (6).

2773 (i) The licensing agency shall promulgate regulations
2774 to implement this subsection (6).

2775 (j) The provisions of this subsection (6) shall not
2776 apply to:

2777 (i) Applicants and employees of the University of
2778 Mississippi Medical Center for whom criminal history record checks
2779 and fingerprinting are obtained in accordance with Section
2780 37-115-41; or

2781 (ii) Health care professional/vocational technical
2782 students for whom criminal history record checks and
2783 fingerprinting are obtained in accordance with Section 37-29-232.

2784 (7) The State Board of Health shall promulgate rules,
2785 regulations and standards regarding the operation of adult foster
2786 care facilities and adult day care facilities.

2787 (8) Beginning July 1, 2026, to operate an adult day care
2788 facility in Mississippi, the facility provider shall be licensed
2789 with the licensing division of the State Department of Health.
2790 Mississippi Medicaid waiver providers are required to have a state
2791 license and have a Medicaid provider contract with the Division of
2792 Medicaid.



2793 Facilities shall be licensed to serve clients based on the
2794 size and capacity of the facility. The facilities shall be
2795 required to provide nursing services, nutritional services,
2796 socialization and therapeutic activities. The facilities shall
2797 maintain, at a minimum, a staff-to-client ratio in accordance with
2798 the State Department of Health's standards. Standards governing
2799 the quality of care and services rendered shall be developed with
2800 input from all stakeholders, including the Division of Medicaid.
2801 In addition to providing adult day care services, the licensed
2802 provider is required to offer transportation services consistent
2803 with State Department of Health regulations.

2804 **SECTION 8.** Section 43-13-117.1, Mississippi Code of 1972, is
2805 amended as follows:

2806 43-13-117.1. It is the intent of the Legislature to expand
2807 access to Medicaid-funded home- and community-based services for
2808 eligible nursing facility residents who choose those services.
2809 The Executive Director of the Division of Medicaid is authorized
2810 to transfer funds allocated for nursing facility services for
2811 eligible residents to cover the cost of services available through
2812 the Independent Living Waiver, the Traumatic Brain Injury/Spinal
2813 Cord Injury Waiver, the Elderly and Disabled Waiver, and the
2814 Assisted Living Waiver programs when eligible residents choose
2815 those community services. The amount of funding transferred by
2816 the division shall be sufficient to cover the cost of home- and
2817 community-based waiver services for each eligible nursing



2818 facility * * * ~~residents~~ resident who * * * ~~choose~~ chooses those
2819 services. The number of nursing facility residents who return to
2820 the community and home- and community-based waiver services shall
2821 not count against the total number of waiver slots for which the
2822 Legislature appropriates funding each year. Any funds remaining
2823 in the program when a former nursing facility resident ceases to
2824 participate in a home- and community-based waiver program under
2825 this provision shall be returned to nursing facility funding.

2826 **SECTION 9.** Section 43-13-117.7, Mississippi Code of 1972, is
2827 amended as follows:

2828 43-13-117.7. Notwithstanding any other provisions of Section
2829 43-13-117, the division shall not reimburse or provide coverage
2830 for gender transition procedures for * * * ~~a~~ any person * * *
2831 ~~under eighteen (18) years of age. As used in this section, the~~
2832 ~~term "gender transition procedures" means the same as defined in~~
2833 ~~Section 41-141-3.~~

2834 **SECTION 10.** Section 37-33-167, Mississippi Code of 1972, is
2835 amended as follows:

2836 37-33-167. The State Department of Rehabilitation Services,
2837 through the Office of Disability Determination Services, may enter
2838 into agreements with the federal Social Security Administration or
2839 its successor and other state agencies for the purpose of
2840 performing eligibility determinations for Medicaid assistance
2841 payments for those persons who qualify therefor under Section
2842 43-13-115 * * * ~~(4)~~, and may adopt such methods of administration



2843 as may be necessary to secure the full benefits of federal
2844 appropriations for medical assistance for such persons.

2845 **SECTION 11.** Section 43-13-145, Mississippi Code of 1972, is
2846 amended as follows:

2847 43-13-145. (1) (a) Upon each nursing facility licensed by
2848 the State of Mississippi, there is levied an assessment in an
2849 amount set by the division, equal to the maximum rate allowed by
2850 federal law or regulation, for each licensed and occupied bed of
2851 the facility.

2852 (b) A nursing facility is exempt from the assessment
2853 levied under this subsection if the facility is operated under the
2854 direction and control of:

2855 (i) The United States Veterans Administration or
2856 other agency or department of the United States government; or

2857 (ii) The State Veterans Affairs Board.

2858 (2) (a) Upon each intermediate care facility for
2859 individuals with intellectual disabilities licensed by the State
2860 of Mississippi, there is levied an assessment in an amount set by
2861 the division, equal to the maximum rate allowed by federal law or
2862 regulation, for each licensed and occupied bed of the facility.

2863 (b) An intermediate care facility for individuals with
2864 intellectual disabilities is exempt from the assessment levied
2865 under this subsection if the facility is operated under the
2866 direction and control of:



2867 (i) The United States Veterans Administration or
2868 other agency or department of the United States government;
2869 (ii) The State Veterans Affairs Board; or
2870 (iii) The University of Mississippi Medical
2871 Center.

2872 (3) (a) Upon each psychiatric residential treatment
2873 facility licensed by the State of Mississippi, there is levied an
2874 assessment in an amount set by the division, equal to the maximum
2875 rate allowed by federal law or regulation, for each licensed and
2876 occupied bed of the facility.

2877 (b) A psychiatric residential treatment facility is
2878 exempt from the assessment levied under this subsection if the
2879 facility is operated under the direction and control of:

2880 (i) The United States Veterans Administration or
2881 other agency or department of the United States government;
2882 (ii) The University of Mississippi Medical Center;
2883 or

2884 (iii) A state agency or a state facility that
2885 either provides its own state match through intergovernmental
2886 transfer or certification of funds to the division.

2887 (4) Hospital assessment.

2888 (a) (i) Subject to and upon fulfillment of the
2889 requirements and conditions of paragraph (f) below, and
2890 notwithstanding any other provisions of this section, an annual
2891 assessment on each hospital licensed in the state is imposed on



2892 each non-Medicare hospital inpatient day as defined below at a
2893 rate that is determined by dividing the sum prescribed in this
2894 subparagraph (i), plus the nonfederal share necessary to maximize
2895 the Disproportionate Share Hospital (DSH) and Medicare Upper
2896 Payment Limits (UPL) Program payments and hospital access payments
2897 and such other supplemental payments as may be developed pursuant
2898 to Section 43-13-117(A)(18), by the total number of non-Medicare
2899 hospital inpatient days as defined below for all licensed
2900 Mississippi hospitals, except as provided in paragraph (d) below.
2901 If the state-matching funds percentage for the Mississippi
2902 Medicaid program is sixteen percent (16%) or less, the sum used in
2903 the formula under this subparagraph (i) shall be Seventy-four
2904 Million Dollars (\$74,000,000.00). If the state-matching funds
2905 percentage for the Mississippi Medicaid program is twenty-four
2906 percent (24%) or higher, the sum used in the formula under this
2907 subparagraph (i) shall be One Hundred Four Million Dollars
2908 (\$104,000,000.00). If the state-matching funds percentage for the
2909 Mississippi Medicaid program is between sixteen percent (16%) and
2910 twenty-four percent (24%), the sum used in the formula under this
2911 subparagraph (i) shall be a pro rata amount determined as follows:
2912 the current state-matching funds percentage rate minus sixteen
2913 percent (16%) divided by eight percent (8%) multiplied by Thirty
2914 Million Dollars (\$30,000,000.00) and add that amount to
2915 Seventy-four Million Dollars (\$74,000,000.00). However, no
2916 assessment in a quarter under this subparagraph (i) may exceed the



2917 assessment in the previous quarter by more than Three Million
2918 Seven Hundred Fifty Thousand Dollars (\$3,750,000.00) (which would
2919 be Fifteen Million Dollars (\$15,000,000.00) on an annualized
2920 basis), unless such increase is to maximize federal funds that are
2921 available to reimburse hospitals for services provided under new
2922 programs for hospitals, for increased supplemental payment
2923 programs for hospitals or to assist with state matching funds as
2924 authorized by the Legislature. The division shall publish the
2925 state-matching funds percentage rate applicable to the Mississippi
2926 Medicaid program on the tenth day of the first month of each
2927 quarter and the assessment determined under the formula prescribed
2928 above shall be applicable in the quarter following any adjustment
2929 in that state-matching funds percentage rate. The division shall
2930 notify each hospital licensed in the state as to any projected
2931 increases or decreases in the assessment determined under this
2932 subparagraph (i). However, if the Centers for Medicare and
2933 Medicaid Services (CMS) does not approve the provision in Section
2934 43-13-117(39) requiring the division to reimburse crossover claims
2935 for inpatient hospital services and crossover claims covered under
2936 Medicare Part B for dually eligible beneficiaries in the same
2937 manner that was in effect on January 1, 2008, the sum that
2938 otherwise would have been used in the formula under this
2939 subparagraph (i) shall be reduced by Seven Million Dollars
2940 (\$7,000,000.00).



2941 (ii) In addition to the assessment provided under
2942 subparagraph (i), an additional annual assessment on each hospital
2943 licensed in the state is imposed on each non-Medicare hospital
2944 inpatient day as defined below at a rate that is determined by
2945 dividing twenty-five percent (25%) of any provider reductions in
2946 the Medicaid program as authorized in Section 43-13-117(F) for
2947 that fiscal year up to the following maximum amount, plus the
2948 nonfederal share necessary to maximize the Disproportionate Share
2949 Hospital (DSH) and inpatient Medicare Upper Payment Limits (UPL)
2950 Program payments and inpatient hospital access payments, by the
2951 total number of non-Medicare hospital inpatient days as defined
2952 below for all licensed Mississippi hospitals: in fiscal year
2953 2010, the maximum amount shall be Twenty-four Million Dollars
2954 (\$24,000,000.00); in fiscal year 2011, the maximum amount shall be
2955 Thirty-two Million Dollars (\$32,000,000.00); and in fiscal year
2956 2012 and thereafter, the maximum amount shall be Forty Million
2957 Dollars (\$40,000,000.00). Any such deficit in the Medicaid
2958 program shall be reviewed by the PEER Committee as provided in
2959 Section 43-13-117(F).

2960 (iii) In addition to the assessments provided in
2961 subparagraphs (i) and (ii), an additional annual assessment on
2962 each hospital licensed in the state is imposed pursuant to the
2963 provisions of Section 43-13-117(F) if the cost-containment
2964 measures described therein have been implemented and there are
2965 insufficient funds in the Health Care Trust Fund to reconcile any



2966 remaining deficit in any fiscal year. If the Governor institutes
2967 any other additional cost-containment measures on any program or
2968 programs authorized under the Medicaid program pursuant to Section
2969 43-13-117(F), hospitals shall be responsible for twenty-five
2970 percent (25%) of any such additional imposed provider cuts, which
2971 shall be in the form of an additional assessment not to exceed the
2972 twenty-five percent (25%) of provider expenditure reductions.
2973 Such additional assessment shall be imposed on each non-Medicare
2974 hospital inpatient day in the same manner as assessments are
2975 imposed under subparagraphs (i) and (ii).

2976 (b) Definitions.

2977 (i) [Deleted]

2978 (ii) For purposes of this subsection (4):

2979 1. "Non-Medicare hospital inpatient day"

2980 means total hospital inpatient days including subcomponent days
2981 less Medicare inpatient days including subcomponent days from the
2982 hospital's most recent Medicare cost report for the second
2983 calendar year preceding the beginning of the state fiscal year, on
2984 file with CMS per the CMS HCRIS database, or cost report submitted
2985 to the Division if the HCRIS database is not available to the
2986 division, as of June 1 of each year.

2987 a. Total hospital inpatient days shall
2988 be the sum of Worksheet S-3, Part 1, column 8 row 14, column 8 row
2989 16, and column 8 row 17, excluding column 8 rows 5 and 6.



2990 b. Hospital Medicare inpatient days
2991 shall be the sum of Worksheet S-3, Part 1, column 6 row 14, column
2992 6 row 16.00, and column 6 row 17, excluding column 6 rows 5 and 6.

2993 c. Inpatient days shall not include
2994 residential treatment or long-term care days.

2995 2. "Subcomponent inpatient day" means the
2996 number of days of care charged to a beneficiary for inpatient
2997 hospital rehabilitation and psychiatric care services in units of
2998 full days. A day begins at midnight and ends twenty-four (24)
2999 hours later. A part of a day, including the day of admission and
3000 day on which a patient returns from leave of absence, counts as a
3001 full day. However, the day of discharge, death, or a day on which
3002 a patient begins a leave of absence is not counted as a day unless
3003 discharge or death occur on the day of admission. If admission
3004 and discharge or death occur on the same day, the day is
3005 considered a day of admission and counts as one (1) subcomponent
3006 inpatient day.

3007 (c) The assessment provided in this subsection is
3008 intended to satisfy and not be in addition to the assessment and
3009 intergovernmental transfers provided in Section 43-13-117(A)(18).
3010 Nothing in this section shall be construed to authorize any state
3011 agency, division or department, or county, municipality or other
3012 local governmental unit to license for revenue, levy or impose any
3013 other tax, fee or assessment upon hospitals in this state not
3014 authorized by a specific statute.



3015 (d) Hospitals operated by the United States Department
3016 of Veterans Affairs and state-operated facilities that provide
3017 only inpatient and outpatient psychiatric services shall not be
3018 subject to the hospital assessment provided in this subsection.

3019 (e) Multihospital systems, closure, merger, change of
3020 ownership and new hospitals.

3021 (i) If a hospital conducts, operates or maintains
3022 more than one (1) hospital licensed by the State Department of
3023 Health, the provider shall pay the hospital assessment for each
3024 hospital separately.

3025 (ii) Notwithstanding any other provision in this
3026 section, if a hospital subject to this assessment operates or
3027 conducts business only for a portion of a fiscal year, the
3028 assessment for the state fiscal year shall be adjusted by
3029 multiplying the assessment by a fraction, the numerator of which
3030 is the number of days in the year during which the hospital
3031 operates, and the denominator of which is three hundred sixty-five
3032 (365). Immediately upon ceasing to operate, the hospital shall
3033 pay the assessment for the year as so adjusted (to the extent not
3034 previously paid).

3035 (iii) The division shall determine the tax for new
3036 hospitals and hospitals that undergo a change of ownership in
3037 accordance with this section, using the best available
3038 information, as determined by the division.

3039 (f) Applicability.



3040 The hospital assessment imposed by this subsection shall not
3041 take effect and/or shall cease to be imposed if:

3042 (i) The assessment is determined to be an
3043 impermissible tax under Title XIX of the Social Security Act; or

3044 (ii) CMS revokes its approval of the division's
3045 2009 Medicaid State Plan Amendment for the methodology for DSH
3046 payments to hospitals under Section 43-13-117(A) (18).

3047 (5) Each health care facility that is subject to the
3048 provisions of this section shall keep and preserve such suitable
3049 books and records as may be necessary to determine the amount of
3050 assessment for which it is liable under this section. The books
3051 and records shall be kept and preserved for a period of not less
3052 than five (5) years, during which time those books and records
3053 shall be open for examination during business hours by the
3054 division, the Department of Revenue, the Office of the Attorney
3055 General and the State Department of Health.

3056 (6) [Deleted]

3057 (7) All assessments collected under this section shall be
3058 deposited in the Medical Care Fund created by Section 43-13-143.

3059 (8) The assessment levied under this section shall be in
3060 addition to any other assessments, taxes or fees levied by law,
3061 and the assessment shall constitute a debt due the State of
3062 Mississippi from the time the assessment is due until it is paid.

3063 (9) (a) If a health care facility that is liable for
3064 payment of an assessment levied by the division does not pay the



3065 assessment when it is due, the division shall give written notice
3066 to the health care facility demanding payment of the assessment
3067 within ten (10) days from the date of delivery of the notice. If
3068 the health care facility fails or refuses to pay the assessment
3069 after receiving the notice and demand from the division, the
3070 division shall withhold from any Medicaid reimbursement payments
3071 that are due to the health care facility the amount of the unpaid
3072 assessment and a penalty of ten percent (10%) of the amount of the
3073 assessment, plus the legal rate of interest until the assessment
3074 is paid in full. If the health care facility does not participate
3075 in the Medicaid program, the division shall turn over to the
3076 Office of the Attorney General the collection of the unpaid
3077 assessment by civil action. In any such civil action, the Office
3078 of the Attorney General shall collect the amount of the unpaid
3079 assessment and a penalty of ten percent (10%) of the amount of the
3080 assessment, plus the legal rate of interest until the assessment
3081 is paid in full.

3082 (b) As an additional or alternative method for
3083 collecting unpaid assessments levied by the division, if a health
3084 care facility fails or refuses to pay the assessment after
3085 receiving notice and demand from the division, the division may
3086 file a notice of a tax lien with the chancery clerk of the county
3087 in which the health care facility is located, for the amount of
3088 the unpaid assessment and a penalty of ten percent (10%) of the
3089 amount of the assessment, plus the legal rate of interest until



3090 the assessment is paid in full. Immediately upon receipt of
3091 notice of the tax lien for the assessment, the chancery clerk
3092 shall forward the notice to the circuit clerk who shall enter the
3093 notice of the tax lien as a judgment upon the judgment roll and
3094 show in the appropriate columns the name of the health care
3095 facility as judgment debtor, the name of the division as judgment
3096 creditor, the amount of the unpaid assessment, and the date and
3097 time of enrollment. The judgment shall be valid as against
3098 mortgagees, pledgees, entrusters, purchasers, judgment creditors
3099 and other persons from the time of filing with the clerk. The
3100 amount of the judgment shall be a debt due the State of
3101 Mississippi and remain a lien upon the tangible property of the
3102 health care facility until the judgment is satisfied. The
3103 judgment shall be the equivalent of any enrolled judgment of a
3104 court of record and shall serve as authority for the issuance of
3105 writs of execution, writs of attachment or other remedial writs.

3106 (10) (a) To further the provisions of Section
3107 43-13-117(A)(18), the Division of Medicaid shall submit to the
3108 Centers for Medicare and Medicaid Services (CMS) any documents
3109 regarding the hospital assessment established under subsection (4)
3110 of this section. In addition to defining the assessment
3111 established in subsection (4) of this section if necessary, the
3112 documents shall describe any supplement payment programs and/or
3113 payment methodologies as authorized in Section 43-13-117(A)(18) if
3114 necessary.



3115 (b) All hospitals satisfying the minimum federal DSH
3116 eligibility requirements (Section 1923(d) of the Social Security
3117 Act) may, subject to OBRA 1993 payment limitations, receive a DSH
3118 payment. This DSH payment shall expend the balance of the federal
3119 DSH allotment and associated state share not utilized in DSH
3120 payments to state-owned institutions for treatment of mental
3121 diseases. The payment to each hospital shall be calculated by
3122 applying a uniform percentage to the uninsured costs of each
3123 eligible hospital, excluding state-owned institutions for
3124 treatment of mental diseases; however, that percentage for a
3125 state-owned teaching hospital located in Hinds County shall be
3126 multiplied by a factor of two (2).

3127 (11) The division shall implement DSH and supplemental
3128 payment calculation methodologies that result in the maximization
3129 of available federal funds.

3130 (12) The DSH payments shall be paid on or before December
3131 31, March 31, and June 30 of each fiscal year, in increments of
3132 one-third (1/3) of the total calculated DSH amounts. Supplemental
3133 payments developed pursuant to Section 43-13-117(A)(18) shall be
3134 paid monthly.

3135 (13) Payment.

3136 (a) The hospital assessment as described in subsection
3137 (4) for the nonfederal share necessary to maximize the Medicare
3138 Upper Payments Limits (UPL) Program payments and hospital access
3139 payments and such other supplemental payments as may be developed



3140 pursuant to Section 43-3-117(A) (18) shall be assessed and
3141 collected monthly no later than the fifteenth calendar day of each
3142 month.

3143 (b) The hospital assessment as described in subsection
3144 (4) for the nonfederal share necessary to maximize the
3145 Disproportionate Share Hospital (DSH) payments shall be assessed
3146 and collected on December 15, March 15 and June 15.

3147 (c) The annual hospital assessment and any additional
3148 hospital assessment as described in subsection (4) shall be
3149 assessed and collected on September 15 and on the 15th of each
3150 month from December through June.

3151 (14) If for any reason any part of the plan for annual DSH
3152 and supplemental payment programs to hospitals provided under
3153 subsection (10) of this section and/or developed pursuant to
3154 Section 43-13-117(A) (18) is not approved by CMS, the remainder of
3155 the plan shall remain in full force and effect.

3156 (15) Nothing in this section shall prevent the Division of
3157 Medicaid from facilitating participation in Medicaid supplemental
3158 hospital payment programs by a hospital located in a county
3159 contiguous to the State of Mississippi that is also authorized by
3160 federal law to submit intergovernmental transfers (IGTs) to the
3161 State of Mississippi to fund the state share of the hospital's
3162 supplemental and/or MHAP payments.

3163 (16) This section shall stand repealed on July 1, 2028.



3164 **SECTION 12.** Section 43-13-115.1, Mississippi Code of 1972,
3165 is amended as follows:

3166 43-13-115.1. (1) Ambulatory prenatal care shall be
3167 available to a pregnant woman under this article during a
3168 presumptive eligibility period in accordance with the provisions
3169 of this section.

3170 (2) For purposes of this section, the following terms shall
3171 be defined as provided in this subsection:

3172 (a) "Presumptive eligibility" means a reasonable
3173 determination of Medicaid eligibility of a pregnant woman made by
3174 a qualified provider based only on the countable family income of
3175 the woman, which allows the woman to receive ambulatory prenatal
3176 care under this article during a presumptive eligibility period
3177 while the Division of Medicaid makes a determination with respect
3178 to the eligibility of the woman for Medicaid.

3179 (b) "Presumptive eligibility period" means, with
3180 respect to a pregnant woman, the period that:

3181 (i) Begins with the date on which a qualified
3182 provider determines, on the basis of preliminary information, that
3183 the total countable net family income of the woman does not exceed
3184 the income limits for eligibility of pregnant women in the
3185 Medicaid state plan; and

3186 (ii) Ends with, and includes, the earlier of:

3187 1. The day on which a determination is made
3188 with respect to the eligibility of the woman for Medicaid;



3189 2. In the case of a woman who does not file
3190 an application by the last day of the month following the month
3191 during which the provider makes the determination referred to in
3192 subparagraph (i) of this paragraph, such last day; or

3193 3. Sixty (60) days after the day that the
3194 provider makes the determination referred to in subparagraph (i)
3195 of this paragraph.

3196 (c) "Qualified provider" means any provider that meets
3197 the definition of "qualified provider" under 42 USC Section
3198 1396r-1. The term includes, but is not limited to, county health
3199 departments, federally qualified health centers (FQHCs), and other
3200 entities approved and designated by the Division of Medicaid to
3201 conduct presumptive eligibility determinations for pregnant women.

3202 (3) A pregnant woman shall be deemed to be presumptively
3203 eligible for ambulatory prenatal care under this article if a
3204 qualified provider determines, on the basis of preliminary
3205 information, that the total countable net family income of the
3206 woman does not exceed the income limits for eligibility of
3207 pregnant women in the Medicaid state plan. * * * ~~A pregnant woman
3208 must, at a minimum, provide proof of her pregnancy and
3209 documentation of her monthly family income when seeking a
3210 determination of presumptive eligibility.~~ A pregnant woman who is
3211 determined to be presumptively eligible may receive no more than
3212 one (1) presumptive eligibility period per pregnancy.



3213 (4) A qualified provider that determines that a pregnant
3214 woman is presumptively eligible for Medicaid shall:

3215 (a) Notify the Division of Medicaid of the
3216 determination within five (5) working days after the date on which
3217 determination is made; and

3218 (b) Inform the woman at the time the determination is
3219 made that she is required to make application for Medicaid by not
3220 later than the last day of the month following the month during
3221 which the determination is made.

3222 (5) A pregnant woman who is determined by a qualified
3223 provider to be presumptively eligible for Medicaid shall make
3224 application for Medicaid by not later than the last day of the
3225 month following the month during which the determination is made.

3226 (6) The Division of Medicaid shall provide qualified
3227 providers with such forms as are necessary for a pregnant woman to
3228 make application for Medicaid and information on how to assist
3229 such women in completing and filing such forms. The division
3230 shall make those application forms and the application process
3231 itself as simple as possible.

3232 **SECTION 13.** Section 41-7-191, Mississippi Code of 1972, is
3233 amended as follows:

3234 41-7-191. (1) No person shall engage in any of the
3235 following activities without obtaining the required certificate of
3236 need:



3237 (a) The construction, development or other
3238 establishment of a new health care facility, which establishment
3239 shall include the reopening of a health care facility that has
3240 ceased to operate for a period of sixty (60) months or more;

3241 (b) The relocation of a health care facility or portion
3242 thereof, or major medical equipment, unless such relocation of a
3243 health care facility or portion thereof, or major medical
3244 equipment, which does not involve a capital expenditure by or on
3245 behalf of a health care facility, is within five thousand two
3246 hundred eighty (5,280) feet from the main entrance of the health
3247 care facility;

3248 (c) Any change in the existing bed complement of any
3249 health care facility through the addition or conversion of any
3250 beds or the alteration, modernizing or refurbishing of any unit or
3251 department in which the beds may be located; however, if a health
3252 care facility has voluntarily delicensed some of its existing bed
3253 complement, it may later relicense some or all of its delicensed
3254 beds without the necessity of having to acquire a certificate of
3255 need. The State Department of Health shall maintain a record of
3256 the delicensing health care facility and its voluntarily
3257 delicensed beds and continue counting those beds as part of the
3258 state's total bed count for health care planning purposes. If a
3259 health care facility that has voluntarily delicensed some of its
3260 beds later desires to relicense some or all of its voluntarily
3261 delicensed beds, it shall notify the State Department of Health of



3262 its intent to increase the number of its licensed beds. The State
3263 Department of Health shall survey the health care facility within
3264 thirty (30) days of that notice and, if appropriate, issue the
3265 health care facility a new license reflecting the new contingent
3266 of beds. However, in no event may a health care facility that has
3267 voluntarily delicensed some of its beds be reissued a license to
3268 operate beds in excess of its bed count before the voluntary
3269 delicensure of some of its beds without seeking certificate of
3270 need approval;

3271 (d) Offering of the following health services if those
3272 services have not been provided on a regular basis by the proposed
3273 provider of such services within the period of twelve (12) months
3274 prior to the time such services would be offered:

- 3275 (i) Open-heart surgery services;
- 3276 (ii) Cardiac catheterization services;
- 3277 (iii) Comprehensive inpatient rehabilitation
3278 services;
- 3279 (iv) Licensed psychiatric services;
- 3280 (v) Licensed chemical dependency services;
- 3281 (vi) Radiation therapy services;
- 3282 (vii) Diagnostic imaging services of an invasive
3283 nature, i.e. invasive digital angiography;
- 3284 (viii) Nursing home care as defined in
3285 subparagraphs (iv), (vi) and (viii) of Section 41-7-173(h);
- 3286 (ix) Home health services;



3287 (x) Swing-bed services;
3288 (xi) Ambulatory surgical services;
3289 (xii) Magnetic resonance imaging services;
3290 (xiii) [Deleted]
3291 (xiv) Long-term care hospital services;
3292 (xv) Positron emission tomography (PET) services;
3293 (e) The relocation of one or more health services from
3294 one physical facility or site to another physical facility or
3295 site, unless such relocation, which does not involve a capital
3296 expenditure by or on behalf of a health care facility, (i) is to a
3297 physical facility or site within five thousand two hundred eighty
3298 (5,280) feet from the main entrance of the health care facility
3299 where the health care service is located, or (ii) is the result of
3300 an order of a court of appropriate jurisdiction or a result of
3301 pending litigation in such court, or by order of the State
3302 Department of Health, or by order of any other agency or legal
3303 entity of the state, the federal government, or any political
3304 subdivision of either, whose order is also approved by the State
3305 Department of Health;
3306 (f) The acquisition or otherwise control of any major
3307 medical equipment for the provision of medical services; however,
3308 (i) the acquisition of any major medical equipment used only for
3309 research purposes, and (ii) the acquisition of major medical
3310 equipment to replace medical equipment for which a facility is
3311 already providing medical services and for which the State



3312 Department of Health has been notified before the date of such
3313 acquisition shall be exempt from this paragraph; an acquisition
3314 for less than fair market value must be reviewed, if the
3315 acquisition at fair market value would be subject to review;

3316 (g) Changes of ownership of existing health care
3317 facilities in which a notice of intent is not filed with the State
3318 Department of Health at least thirty (30) days prior to the date
3319 such change of ownership occurs, or a change in services or bed
3320 capacity as prescribed in paragraph (c) or (d) of this subsection
3321 as a result of the change of ownership; an acquisition for less
3322 than fair market value must be reviewed, if the acquisition at
3323 fair market value would be subject to review;

3324 (h) The change of ownership of any health care facility
3325 defined in subparagraphs (iv), (vi) and (viii) of Section
3326 41-7-173(h), in which a notice of intent as described in paragraph
3327 (g) has not been filed and if the Executive Director, Division of
3328 Medicaid, Office of the Governor, has not certified in writing
3329 that there will be no increase in allowable costs to Medicaid from
3330 revaluation of the assets or from increased interest and
3331 depreciation as a result of the proposed change of ownership;

3332 (i) Any activity described in paragraphs (a) through
3333 (h) if undertaken by any person if that same activity would
3334 require certificate of need approval if undertaken by a health
3335 care facility;



3336 (j) Any capital expenditure or deferred capital
3337 expenditure by or on behalf of a health care facility not covered
3338 by paragraphs (a) through (h);

3339 (k) The contracting of a health care facility as
3340 defined in subparagraphs (i) through (viii) of Section 41-7-173(h)
3341 to establish a home office, subunit, or branch office in the space
3342 operated as a health care facility through a formal arrangement
3343 with an existing health care facility as defined in subparagraph
3344 (ix) of Section 41-7-173(h);

3345 (l) The replacement or relocation of a health care
3346 facility designated as a critical access hospital shall be exempt
3347 from subsection (1) of this section so long as the critical access
3348 hospital complies with all applicable federal law and regulations
3349 regarding such replacement or relocation;

3350 (m) Reopening a health care facility that has ceased to
3351 operate for a period of sixty (60) months or more, which reopening
3352 requires a certificate of need for the establishment of a new
3353 health care facility.

3354 (2) The State Department of Health shall not grant approval
3355 for or issue a certificate of need to any person proposing the new
3356 construction of, addition to, or expansion of any health care
3357 facility defined in subparagraphs (iv) (skilled nursing facility)
3358 and (vi) (intermediate care facility) of Section 41-7-173(h) or
3359 the conversion of vacant hospital beds to provide skilled or
3360 intermediate nursing home care, except as hereinafter authorized:



3361 (a) The department may issue a certificate of need to
3362 any person proposing the new construction of any health care
3363 facility defined in subparagraphs (iv) and (vi) of Section
3364 41-7-173(h) as part of a life care retirement facility, in any
3365 county bordering on the Gulf of Mexico in which is located a
3366 National Aeronautics and Space Administration facility, not to
3367 exceed forty (40) beds. From and after July 1, 1999, there shall
3368 be no prohibition or restrictions on participation in the Medicaid
3369 program (Section 43-13-101 et seq.) for the beds in the health
3370 care facility that were authorized under this paragraph (a).

3371 (b) The department may issue certificates of need in
3372 Harrison County to provide skilled nursing home care for
3373 Alzheimer's disease patients and other patients, not to exceed one
3374 hundred fifty (150) beds. From and after July 1, 1999, there
3375 shall be no prohibition or restrictions on participation in the
3376 Medicaid program (Section 43-13-101 et seq.) for the beds in the
3377 nursing facilities that were authorized under this paragraph (b).

3378 (c) The department may issue a certificate of need for
3379 the addition to or expansion of any skilled nursing facility that
3380 is part of an existing continuing care retirement community
3381 located in Madison County, provided that the recipient of the
3382 certificate of need agrees in writing that the skilled nursing
3383 facility will not at any time participate in the Medicaid program
3384 (Section 43-13-101 et seq.) or admit or keep any patients in the
3385 skilled nursing facility who are participating in the Medicaid



3386 program. This written agreement by the recipient of the
3387 certificate of need shall be fully binding on any subsequent owner
3388 of the skilled nursing facility, if the ownership of the facility
3389 is transferred at any time after the issuance of the certificate
3390 of need. Agreement that the skilled nursing facility will not
3391 participate in the Medicaid program shall be a condition of the
3392 issuance of a certificate of need to any person under this
3393 paragraph (c), and if such skilled nursing facility at any time
3394 after the issuance of the certificate of need, regardless of the
3395 ownership of the facility, participates in the Medicaid program or
3396 admits or keeps any patients in the facility who are participating
3397 in the Medicaid program, the State Department of Health shall
3398 revoke the certificate of need, if it is still outstanding, and
3399 shall deny or revoke the license of the skilled nursing facility,
3400 at the time that the department determines, after a hearing
3401 complying with due process, that the facility has failed to comply
3402 with any of the conditions upon which the certificate of need was
3403 issued, as provided in this paragraph and in the written agreement
3404 by the recipient of the certificate of need. The total number of
3405 beds that may be authorized under the authority of this paragraph
3406 (c) shall not exceed sixty (60) beds.

3407 (d) The State Department of Health may issue a
3408 certificate of need to any hospital located in DeSoto County for
3409 the new construction of a skilled nursing facility, not to exceed
3410 one hundred twenty (120) beds, in DeSoto County. From and after



3411 July 1, 1999, there shall be no prohibition or restrictions on
3412 participation in the Medicaid program (Section 43-13-101 et seq.)
3413 for the beds in the nursing facility that were authorized under
3414 this paragraph (d).

3415 (e) The State Department of Health may issue a
3416 certificate of need for the construction of a nursing facility or
3417 the conversion of beds to nursing facility beds at a personal care
3418 facility for the elderly in Lowndes County that is owned and
3419 operated by a Mississippi nonprofit corporation, not to exceed
3420 sixty (60) beds. From and after July 1, 1999, there shall be no
3421 prohibition or restrictions on participation in the Medicaid
3422 program (Section 43-13-101 et seq.) for the beds in the nursing
3423 facility that were authorized under this paragraph (e).

3424 (f) The State Department of Health may issue a
3425 certificate of need for conversion of a county hospital facility
3426 in Itawamba County to a nursing facility, not to exceed sixty (60)
3427 beds, including any necessary construction, renovation or
3428 expansion. From and after July 1, 1999, there shall be no
3429 prohibition or restrictions on participation in the Medicaid
3430 program (Section 43-13-101 et seq.) for the beds in the nursing
3431 facility that were authorized under this paragraph (f).

3432 (g) The State Department of Health may issue a
3433 certificate of need for the construction or expansion of nursing
3434 facility beds or the conversion of other beds to nursing facility
3435 beds in either Hinds, Madison or Rankin County, not to exceed



3436 sixty (60) beds. From and after July 1, 1999, there shall be no
3437 prohibition or restrictions on participation in the Medicaid
3438 program (Section 43-13-101 et seq.) for the beds in the nursing
3439 facility that were authorized under this paragraph (g).

3440 (h) The State Department of Health may issue a
3441 certificate of need for the construction or expansion of nursing
3442 facility beds or the conversion of other beds to nursing facility
3443 beds in either Hancock, Harrison or Jackson County, not to exceed
3444 sixty (60) beds. From and after July 1, 1999, there shall be no
3445 prohibition or restrictions on participation in the Medicaid
3446 program (Section 43-13-101 et seq.) for the beds in the facility
3447 that were authorized under this paragraph (h).

3448 (i) The department may issue a certificate of need for
3449 the new construction of a skilled nursing facility in Leake
3450 County, provided that the recipient of the certificate of need
3451 agrees in writing that the skilled nursing facility will not at
3452 any time participate in the Medicaid program (Section 43-13-101 et
3453 seq.) or admit or keep any patients in the skilled nursing
3454 facility who are participating in the Medicaid program. This
3455 written agreement by the recipient of the certificate of need
3456 shall be fully binding on any subsequent owner of the skilled
3457 nursing facility, if the ownership of the facility is transferred
3458 at any time after the issuance of the certificate of need.
3459 Agreement that the skilled nursing facility will not participate
3460 in the Medicaid program shall be a condition of the issuance of a



3461 certificate of need to any person under this paragraph (i), and if
3462 such skilled nursing facility at any time after the issuance of
3463 the certificate of need, regardless of the ownership of the
3464 facility, participates in the Medicaid program or admits or keeps
3465 any patients in the facility who are participating in the Medicaid
3466 program, the State Department of Health shall revoke the
3467 certificate of need, if it is still outstanding, and shall deny or
3468 revoke the license of the skilled nursing facility, at the time
3469 that the department determines, after a hearing complying with due
3470 process, that the facility has failed to comply with any of the
3471 conditions upon which the certificate of need was issued, as
3472 provided in this paragraph and in the written agreement by the
3473 recipient of the certificate of need. The provision of Section
3474 41-7-193(1) regarding substantial compliance of the projection of
3475 need as reported in the current State Health Plan is waived for
3476 the purposes of this paragraph. The total number of nursing
3477 facility beds that may be authorized by any certificate of need
3478 issued under this paragraph (i) shall not exceed sixty (60) beds.
3479 If the skilled nursing facility authorized by the certificate of
3480 need issued under this paragraph is not constructed and fully
3481 operational within eighteen (18) months after July 1, 1994, the
3482 State Department of Health, after a hearing complying with due
3483 process, shall revoke the certificate of need, if it is still
3484 outstanding, and shall not issue a license for the skilled nursing



3485 facility at any time after the expiration of the eighteen-month
3486 period.

3487 (j) The department may issue certificates of need to
3488 allow any existing freestanding long-term care facility in
3489 Tishomingo County and Hancock County that on July 1, 1995, is
3490 licensed with fewer than sixty (60) beds. For the purposes of
3491 this paragraph (j), the provisions of Section 41-7-193(1)
3492 requiring substantial compliance with the projection of need as
3493 reported in the current State Health Plan are waived. From and
3494 after July 1, 1999, there shall be no prohibition or restrictions
3495 on participation in the Medicaid program (Section 43-13-101 et
3496 seq.) for the beds in the long-term care facilities that were
3497 authorized under this paragraph (j).

3498 (k) The department may issue a certificate of need for
3499 the construction of a nursing facility at a continuing care
3500 retirement community in Lowndes County. The total number of beds
3501 that may be authorized under the authority of this paragraph (k)
3502 shall not exceed sixty (60) beds. From and after July 1, 2001,
3503 the prohibition on the facility participating in the Medicaid
3504 program (Section 43-13-101 et seq.) that was a condition of
3505 issuance of the certificate of need under this paragraph (k) shall
3506 be revised as follows: The nursing facility may participate in
3507 the Medicaid program from and after July 1, 2001, if the owner of
3508 the facility on July 1, 2001, agrees in writing that no more than
3509 thirty (30) of the beds at the facility will be certified for



3510 participation in the Medicaid program, and that no claim will be
3511 submitted for Medicaid reimbursement for more than thirty (30)
3512 patients in the facility in any month or for any patient in the
3513 facility who is in a bed that is not Medicaid-certified. This
3514 written agreement by the owner of the facility shall be a
3515 condition of licensure of the facility, and the agreement shall be
3516 fully binding on any subsequent owner of the facility if the
3517 ownership of the facility is transferred at any time after July 1,
3518 2001. After this written agreement is executed, the Division of
3519 Medicaid and the State Department of Health shall not certify more
3520 than thirty (30) of the beds in the facility for participation in
3521 the Medicaid program. If the facility violates the terms of the
3522 written agreement by admitting or keeping in the facility on a
3523 regular or continuing basis more than thirty (30) patients who are
3524 participating in the Medicaid program, the State Department of
3525 Health shall revoke the license of the facility, at the time that
3526 the department determines, after a hearing complying with due
3527 process, that the facility has violated the written agreement.

3528 (1) Provided that funds are specifically appropriated
3529 therefor by the Legislature, the department may issue a
3530 certificate of need to a rehabilitation hospital in Hinds County
3531 for the construction of a sixty-bed long-term care nursing
3532 facility dedicated to the care and treatment of persons with
3533 severe disabilities including persons with spinal cord and
3534 closed-head injuries and ventilator dependent patients. The



3535 provisions of Section 41-7-193(1) regarding substantial compliance
3536 with projection of need as reported in the current State Health
3537 Plan are waived for the purpose of this paragraph.

3538 (m) The State Department of Health may issue a
3539 certificate of need to a county-owned hospital in the Second
3540 Judicial District of Panola County for the conversion of not more
3541 than seventy-two (72) hospital beds to nursing facility beds,
3542 provided that the recipient of the certificate of need agrees in
3543 writing that none of the beds at the nursing facility will be
3544 certified for participation in the Medicaid program (Section
3545 43-13-101 et seq.), and that no claim will be submitted for
3546 Medicaid reimbursement in the nursing facility in any day or for
3547 any patient in the nursing facility. This written agreement by
3548 the recipient of the certificate of need shall be a condition of
3549 the issuance of the certificate of need under this paragraph, and
3550 the agreement shall be fully binding on any subsequent owner of
3551 the nursing facility if the ownership of the nursing facility is
3552 transferred at any time after the issuance of the certificate of
3553 need. After this written agreement is executed, the Division of
3554 Medicaid and the State Department of Health shall not certify any
3555 of the beds in the nursing facility for participation in the
3556 Medicaid program. If the nursing facility violates the terms of
3557 the written agreement by admitting or keeping in the nursing
3558 facility on a regular or continuing basis any patients who are
3559 participating in the Medicaid program, the State Department of



3560 Health shall revoke the license of the nursing facility, at the
3561 time that the department determines, after a hearing complying
3562 with due process, that the nursing facility has violated the
3563 condition upon which the certificate of need was issued, as
3564 provided in this paragraph and in the written agreement. If the
3565 certificate of need authorized under this paragraph is not issued
3566 within twelve (12) months after July 1, 2001, the department shall
3567 deny the application for the certificate of need and shall not
3568 issue the certificate of need at any time after the twelve-month
3569 period, unless the issuance is contested. If the certificate of
3570 need is issued and substantial construction of the nursing
3571 facility beds has not commenced within eighteen (18) months after
3572 July 1, 2001, the State Department of Health, after a hearing
3573 complying with due process, shall revoke the certificate of need
3574 if it is still outstanding, and the department shall not issue a
3575 license for the nursing facility at any time after the
3576 eighteen-month period. However, if the issuance of the
3577 certificate of need is contested, the department shall require
3578 substantial construction of the nursing facility beds within six
3579 (6) months after final adjudication on the issuance of the
3580 certificate of need.

3581 (n) The department may issue a certificate of need for
3582 the new construction, addition or conversion of skilled nursing
3583 facility beds in Madison County, provided that the recipient of
3584 the certificate of need agrees in writing that the skilled nursing



3585 facility will not at any time participate in the Medicaid program
3586 (Section 43-13-101 et seq.) or admit or keep any patients in the
3587 skilled nursing facility who are participating in the Medicaid
3588 program. This written agreement by the recipient of the
3589 certificate of need shall be fully binding on any subsequent owner
3590 of the skilled nursing facility, if the ownership of the facility
3591 is transferred at any time after the issuance of the certificate
3592 of need. Agreement that the skilled nursing facility will not
3593 participate in the Medicaid program shall be a condition of the
3594 issuance of a certificate of need to any person under this
3595 paragraph (n), and if such skilled nursing facility at any time
3596 after the issuance of the certificate of need, regardless of the
3597 ownership of the facility, participates in the Medicaid program or
3598 admits or keeps any patients in the facility who are participating
3599 in the Medicaid program, the State Department of Health shall
3600 revoke the certificate of need, if it is still outstanding, and
3601 shall deny or revoke the license of the skilled nursing facility,
3602 at the time that the department determines, after a hearing
3603 complying with due process, that the facility has failed to comply
3604 with any of the conditions upon which the certificate of need was
3605 issued, as provided in this paragraph and in the written agreement
3606 by the recipient of the certificate of need. The total number of
3607 nursing facility beds that may be authorized by any certificate of
3608 need issued under this paragraph (n) shall not exceed sixty (60)
3609 beds. If the certificate of need authorized under this paragraph



3610 is not issued within twelve (12) months after July 1, 1998, the
3611 department shall deny the application for the certificate of need
3612 and shall not issue the certificate of need at any time after the
3613 twelve-month period, unless the issuance is contested. If the
3614 certificate of need is issued and substantial construction of the
3615 nursing facility beds has not commenced within eighteen (18)
3616 months after July 1, 1998, the State Department of Health, after a
3617 hearing complying with due process, shall revoke the certificate
3618 of need if it is still outstanding, and the department shall not
3619 issue a license for the nursing facility at any time after the
3620 eighteen-month period. However, if the issuance of the
3621 certificate of need is contested, the department shall require
3622 substantial construction of the nursing facility beds within six
3623 (6) months after final adjudication on the issuance of the
3624 certificate of need.

3625 (o) The department may issue a certificate of need for
3626 the new construction, addition or conversion of skilled nursing
3627 facility beds in Leake County, provided that the recipient of the
3628 certificate of need agrees in writing that the skilled nursing
3629 facility will not at any time participate in the Medicaid program
3630 (Section 43-13-101 et seq.) or admit or keep any patients in the
3631 skilled nursing facility who are participating in the Medicaid
3632 program. This written agreement by the recipient of the
3633 certificate of need shall be fully binding on any subsequent owner
3634 of the skilled nursing facility, if the ownership of the facility



3635 is transferred at any time after the issuance of the certificate
3636 of need. Agreement that the skilled nursing facility will not
3637 participate in the Medicaid program shall be a condition of the
3638 issuance of a certificate of need to any person under this
3639 paragraph (o), and if such skilled nursing facility at any time
3640 after the issuance of the certificate of need, regardless of the
3641 ownership of the facility, participates in the Medicaid program or
3642 admits or keeps any patients in the facility who are participating
3643 in the Medicaid program, the State Department of Health shall
3644 revoke the certificate of need, if it is still outstanding, and
3645 shall deny or revoke the license of the skilled nursing facility,
3646 at the time that the department determines, after a hearing
3647 complying with due process, that the facility has failed to comply
3648 with any of the conditions upon which the certificate of need was
3649 issued, as provided in this paragraph and in the written agreement
3650 by the recipient of the certificate of need. The total number of
3651 nursing facility beds that may be authorized by any certificate of
3652 need issued under this paragraph (o) shall not exceed sixty (60)
3653 beds. If the certificate of need authorized under this paragraph
3654 is not issued within twelve (12) months after July 1, 2001, the
3655 department shall deny the application for the certificate of need
3656 and shall not issue the certificate of need at any time after the
3657 twelve-month period, unless the issuance is contested. If the
3658 certificate of need is issued and substantial construction of the
3659 nursing facility beds has not commenced within eighteen (18)



3660 months after July 1, 2001, the State Department of Health, after a
3661 hearing complying with due process, shall revoke the certificate
3662 of need if it is still outstanding, and the department shall not
3663 issue a license for the nursing facility at any time after the
3664 eighteen-month period. However, if the issuance of the
3665 certificate of need is contested, the department shall require
3666 substantial construction of the nursing facility beds within six
3667 (6) months after final adjudication on the issuance of the
3668 certificate of need.

3669 (p) The department may issue a certificate of need for
3670 the construction of a municipally owned nursing facility within
3671 the Town of Belmont in Tishomingo County, not to exceed sixty (60)
3672 beds, provided that the recipient of the certificate of need
3673 agrees in writing that the skilled nursing facility will not at
3674 any time participate in the Medicaid program (Section 43-13-101 et
3675 seq.) or admit or keep any patients in the skilled nursing
3676 facility who are participating in the Medicaid program. This
3677 written agreement by the recipient of the certificate of need
3678 shall be fully binding on any subsequent owner of the skilled
3679 nursing facility, if the ownership of the facility is transferred
3680 at any time after the issuance of the certificate of need.

3681 Agreement that the skilled nursing facility will not participate
3682 in the Medicaid program shall be a condition of the issuance of a
3683 certificate of need to any person under this paragraph (p), and if
3684 such skilled nursing facility at any time after the issuance of



3685 the certificate of need, regardless of the ownership of the
3686 facility, participates in the Medicaid program or admits or keeps
3687 any patients in the facility who are participating in the Medicaid
3688 program, the State Department of Health shall revoke the
3689 certificate of need, if it is still outstanding, and shall deny or
3690 revoke the license of the skilled nursing facility, at the time
3691 that the department determines, after a hearing complying with due
3692 process, that the facility has failed to comply with any of the
3693 conditions upon which the certificate of need was issued, as
3694 provided in this paragraph and in the written agreement by the
3695 recipient of the certificate of need. The provision of Section
3696 41-7-193(1) regarding substantial compliance of the projection of
3697 need as reported in the current State Health Plan is waived for
3698 the purposes of this paragraph. If the certificate of need
3699 authorized under this paragraph is not issued within twelve (12)
3700 months after July 1, 1998, the department shall deny the
3701 application for the certificate of need and shall not issue the
3702 certificate of need at any time after the twelve-month period,
3703 unless the issuance is contested. If the certificate of need is
3704 issued and substantial construction of the nursing facility beds
3705 has not commenced within eighteen (18) months after July 1, 1998,
3706 the State Department of Health, after a hearing complying with due
3707 process, shall revoke the certificate of need if it is still
3708 outstanding, and the department shall not issue a license for the
3709 nursing facility at any time after the eighteen-month period.



3710 However, if the issuance of the certificate of need is contested,
3711 the department shall require substantial construction of the
3712 nursing facility beds within six (6) months after final
3713 adjudication on the issuance of the certificate of need.

3714 (q) (i) Beginning on July 1, 1999, the State
3715 Department of Health shall issue certificates of need during each
3716 of the next four (4) fiscal years for the construction or
3717 expansion of nursing facility beds or the conversion of other beds
3718 to nursing facility beds in each county in the state having a need
3719 for fifty (50) or more additional nursing facility beds, as shown
3720 in the fiscal year 1999 State Health Plan, in the manner provided
3721 in this paragraph (q). The total number of nursing facility beds
3722 that may be authorized by any certificate of need authorized under
3723 this paragraph (q) shall not exceed sixty (60) beds.

3724 (ii) Subject to the provisions of subparagraph
3725 (v), during each of the next four (4) fiscal years, the department
3726 shall issue six (6) certificates of need for new nursing facility
3727 beds, as follows: During fiscal years 2000, 2001 and 2002, one
3728 (1) certificate of need shall be issued for new nursing facility
3729 beds in the county in each of the four (4) Long-Term Care Planning
3730 Districts designated in the fiscal year 1999 State Health Plan
3731 that has the highest need in the district for those beds; and two
3732 (2) certificates of need shall be issued for new nursing facility
3733 beds in the two (2) counties from the state at large that have the
3734 highest need in the state for those beds, when considering the



3735 need on a statewide basis and without regard to the Long-Term Care
3736 Planning Districts in which the counties are located. During
3737 fiscal year 2003, one (1) certificate of need shall be issued for
3738 new nursing facility beds in any county having a need for fifty
3739 (50) or more additional nursing facility beds, as shown in the
3740 fiscal year 1999 State Health Plan, that has not received a
3741 certificate of need under this paragraph (q) during the three (3)
3742 previous fiscal years. During fiscal year 2000, in addition to
3743 the six (6) certificates of need authorized in this subparagraph,
3744 the department also shall issue a certificate of need for new
3745 nursing facility beds in Amite County and a certificate of need
3746 for new nursing facility beds in Carroll County.

3747 (iii) Subject to the provisions of subparagraph
3748 (v), the certificate of need issued under subparagraph (ii) for
3749 nursing facility beds in each Long-Term Care Planning District
3750 during each fiscal year shall first be available for nursing
3751 facility beds in the county in the district having the highest
3752 need for those beds, as shown in the fiscal year 1999 State Health
3753 Plan. If there are no applications for a certificate of need for
3754 nursing facility beds in the county having the highest need for
3755 those beds by the date specified by the department, then the
3756 certificate of need shall be available for nursing facility beds
3757 in other counties in the district in descending order of the need
3758 for those beds, from the county with the second highest need to



3759 the county with the lowest need, until an application is received
3760 for nursing facility beds in an eligible county in the district.

3761 (iv) Subject to the provisions of subparagraph
3762 (v), the certificate of need issued under subparagraph (ii) for
3763 nursing facility beds in the two (2) counties from the state at
3764 large during each fiscal year shall first be available for nursing
3765 facility beds in the two (2) counties that have the highest need
3766 in the state for those beds, as shown in the fiscal year 1999
3767 State Health Plan, when considering the need on a statewide basis
3768 and without regard to the Long-Term Care Planning Districts in
3769 which the counties are located. If there are no applications for
3770 a certificate of need for nursing facility beds in either of the
3771 two (2) counties having the highest need for those beds on a
3772 statewide basis by the date specified by the department, then the
3773 certificate of need shall be available for nursing facility beds
3774 in other counties from the state at large in descending order of
3775 the need for those beds on a statewide basis, from the county with
3776 the second highest need to the county with the lowest need, until
3777 an application is received for nursing facility beds in an
3778 eligible county from the state at large.

3779 (v) If a certificate of need is authorized to be
3780 issued under this paragraph (q) for nursing facility beds in a
3781 county on the basis of the need in the Long-Term Care Planning
3782 District during any fiscal year of the four-year period, a
3783 certificate of need shall not also be available under this



3784 paragraph (q) for additional nursing facility beds in that county
3785 on the basis of the need in the state at large, and that county
3786 shall be excluded in determining which counties have the highest
3787 need for nursing facility beds in the state at large for that
3788 fiscal year. After a certificate of need has been issued under
3789 this paragraph (q) for nursing facility beds in a county during
3790 any fiscal year of the four-year period, a certificate of need
3791 shall not be available again under this paragraph (q) for
3792 additional nursing facility beds in that county during the
3793 four-year period, and that county shall be excluded in determining
3794 which counties have the highest need for nursing facility beds in
3795 succeeding fiscal years.

3796 (vi) If more than one (1) application is made for
3797 a certificate of need for nursing home facility beds available
3798 under this paragraph (q), in Yalobusha, Newton or Tallahatchie
3799 County, and one (1) of the applicants is a county-owned hospital
3800 located in the county where the nursing facility beds are
3801 available, the department shall give priority to the county-owned
3802 hospital in granting the certificate of need if the following
3803 conditions are met:

3804 1. The county-owned hospital fully meets all
3805 applicable criteria and standards required to obtain a certificate
3806 of need for the nursing facility beds; and

3807 2. The county-owned hospital's qualifications
3808 for the certificate of need, as shown in its application and as



3809 determined by the department, are at least equal to the
3810 qualifications of the other applicants for the certificate of
3811 need.

3812 (r) (i) Beginning on July 1, 1999, the State
3813 Department of Health shall issue certificates of need during each
3814 of the next two (2) fiscal years for the construction or expansion
3815 of nursing facility beds or the conversion of other beds to
3816 nursing facility beds in each of the four (4) Long-Term Care
3817 Planning Districts designated in the fiscal year 1999 State Health
3818 Plan, to provide care exclusively to patients with Alzheimer's
3819 disease.

3820 (ii) Not more than twenty (20) beds may be
3821 authorized by any certificate of need issued under this paragraph
3822 (r), and not more than a total of sixty (60) beds may be
3823 authorized in any Long-Term Care Planning District by all
3824 certificates of need issued under this paragraph (r). However,
3825 the total number of beds that may be authorized by all
3826 certificates of need issued under this paragraph (r) during any
3827 fiscal year shall not exceed one hundred twenty (120) beds, and
3828 the total number of beds that may be authorized in any Long-Term
3829 Care Planning District during any fiscal year shall not exceed
3830 forty (40) beds. Of the certificates of need that are issued for
3831 each Long-Term Care Planning District during the next two (2)
3832 fiscal years, at least one (1) shall be issued for beds in the
3833 northern part of the district, at least one (1) shall be issued



3834 for beds in the central part of the district, and at least one (1)
3835 shall be issued for beds in the southern part of the district.

3836 (iii) The State Department of Health, in
3837 consultation with the Department of Mental Health and the Division
3838 of Medicaid, shall develop and prescribe the staffing levels,
3839 space requirements and other standards and requirements that must
3840 be met with regard to the nursing facility beds authorized under
3841 this paragraph (r) to provide care exclusively to patients with
3842 Alzheimer's disease.

3843 (s) The State Department of Health may issue a
3844 certificate of need to a nonprofit skilled nursing facility using
3845 the Green House model of skilled nursing care and located in Yazoo
3846 City, Yazoo County, Mississippi, for the construction, expansion
3847 or conversion of not more than nineteen (19) nursing facility
3848 beds. For purposes of this paragraph (s), the provisions of
3849 Section 41-7-193(1) requiring substantial compliance with the
3850 projection of need as reported in the current State Health Plan
3851 and the provisions of Section 41-7-197 requiring a formal
3852 certificate of need hearing process are waived. There shall be no
3853 prohibition or restrictions on participation in the Medicaid
3854 program for the person receiving the certificate of need
3855 authorized under this paragraph (s).

3856 (t) The State Department of Health shall issue
3857 certificates of need to the owner of a nursing facility in
3858 operation at the time of Hurricane Katrina in Hancock County that



3859 was not operational on December 31, 2005, because of damage
3860 sustained from Hurricane Katrina to authorize the following: (i)
3861 the construction of a new nursing facility in Harrison County;
3862 (ii) the relocation of forty-nine (49) nursing facility beds from
3863 the Hancock County facility to the new Harrison County facility;
3864 (iii) the establishment of not more than twenty (20) non-Medicaid
3865 nursing facility beds at the Hancock County facility; and (iv) the
3866 establishment of not more than twenty (20) non-Medicaid beds at
3867 the new Harrison County facility. The certificates of need that
3868 authorize the non-Medicaid nursing facility beds under
3869 subparagraphs (iii) and (iv) of this paragraph (t) shall be
3870 subject to the following conditions: The owner of the Hancock
3871 County facility and the new Harrison County facility must agree in
3872 writing that no more than fifty (50) of the beds at the Hancock
3873 County facility and no more than forty-nine (49) of the beds at
3874 the Harrison County facility will be certified for participation
3875 in the Medicaid program, and that no claim will be submitted for
3876 Medicaid reimbursement for more than fifty (50) patients in the
3877 Hancock County facility in any month, or for more than forty-nine
3878 (49) patients in the Harrison County facility in any month, or for
3879 any patient in either facility who is in a bed that is not
3880 Medicaid-certified. This written agreement by the owner of the
3881 nursing facilities shall be a condition of the issuance of the
3882 certificates of need under this paragraph (t), and the agreement
3883 shall be fully binding on any later owner or owners of either



3884 facility if the ownership of either facility is transferred at any
3885 time after the certificates of need are issued. After this
3886 written agreement is executed, the Division of Medicaid and the
3887 State Department of Health shall not certify more than fifty (50)
3888 of the beds at the Hancock County facility or more than forty-nine
3889 (49) of the beds at the Harrison County facility for participation
3890 in the Medicaid program. If the Hancock County facility violates
3891 the terms of the written agreement by admitting or keeping in the
3892 facility on a regular or continuing basis more than fifty (50)
3893 patients who are participating in the Medicaid program, or if the
3894 Harrison County facility violates the terms of the written
3895 agreement by admitting or keeping in the facility on a regular or
3896 continuing basis more than forty-nine (49) patients who are
3897 participating in the Medicaid program, the State Department of
3898 Health shall revoke the license of the facility that is in
3899 violation of the agreement, at the time that the department
3900 determines, after a hearing complying with due process, that the
3901 facility has violated the agreement.

3902 (u) The State Department of Health shall issue a
3903 certificate of need to a nonprofit venture for the establishment,
3904 construction and operation of a skilled nursing facility of not
3905 more than sixty (60) beds to provide skilled nursing care for
3906 ventilator dependent or otherwise medically dependent pediatric
3907 patients who require medical and nursing care or rehabilitation
3908 services to be located in a county in which an academic medical



3909 center and a children's hospital are located, and for any
3910 construction and for the acquisition of equipment related to those
3911 beds. The facility shall be authorized to keep such ventilator
3912 dependent or otherwise medically dependent pediatric patients
3913 beyond age twenty-one (21) in accordance with regulations of the
3914 State Board of Health. For purposes of this paragraph (u), the
3915 provisions of Section 41-7-193(1) requiring substantial compliance
3916 with the projection of need as reported in the current State
3917 Health Plan are waived, and the provisions of Section 41-7-197
3918 requiring a formal certificate of need hearing process are waived.
3919 The beds authorized by this paragraph shall be counted as
3920 pediatric skilled nursing facility beds for health planning
3921 purposes under Section 41-7-171 et seq. There shall be no
3922 prohibition of or restrictions on participation in the Medicaid
3923 program for the person receiving the certificate of need
3924 authorized by this paragraph.

3925 (3) The State Department of Health may grant approval for
3926 and issue certificates of need to any person proposing the new
3927 construction of, addition to, conversion of beds of or expansion
3928 of any health care facility defined in subparagraph (x)
3929 (psychiatric residential treatment facility) of Section
3930 41-7-173(h). The total number of beds which may be authorized by
3931 such certificates of need shall not exceed three hundred
3932 thirty-four (334) beds for the entire state.



3933 (a) Of the total number of beds authorized under this
3934 subsection, the department shall issue a certificate of need to a
3935 privately owned psychiatric residential treatment facility in
3936 Simpson County for the conversion of sixteen (16) intermediate
3937 care facility for individuals with intellectual disabilities
3938 (ICF-IID) beds to psychiatric residential treatment facility beds,
3939 provided that facility agrees in writing that the facility shall
3940 give priority for the use of those sixteen (16) beds to
3941 Mississippi residents who are presently being treated in
3942 out-of-state facilities.

3943 (b) Of the total number of beds authorized under this
3944 subsection, the department may issue a certificate or certificates
3945 of need for the construction or expansion of psychiatric
3946 residential treatment facility beds or the conversion of other
3947 beds to psychiatric residential treatment facility beds in Warren
3948 County, not to exceed sixty (60) psychiatric residential treatment
3949 facility beds, provided that the facility agrees in writing that
3950 no more than thirty (30) of the beds at the psychiatric
3951 residential treatment facility will be certified for participation
3952 in the Medicaid program (Section 43-13-101 et seq.) for the use of
3953 any patients other than those who are participating only in the
3954 Medicaid program of another state, and that no claim will be
3955 submitted to the Division of Medicaid for Medicaid reimbursement
3956 for more than thirty (30) patients in the psychiatric residential
3957 treatment facility in any day or for any patient in the



3958 psychiatric residential treatment facility who is in a bed that is
3959 not Medicaid-certified. This written agreement by the recipient
3960 of the certificate of need shall be a condition of the issuance of
3961 the certificate of need under this paragraph, and the agreement
3962 shall be fully binding on any subsequent owner of the psychiatric
3963 residential treatment facility if the ownership of the facility is
3964 transferred at any time after the issuance of the certificate of
3965 need. After this written agreement is executed, the Division of
3966 Medicaid and the State Department of Health shall not certify more
3967 than thirty (30) of the beds in the psychiatric residential
3968 treatment facility for participation in the Medicaid program for
3969 the use of any patients other than those who are participating
3970 only in the Medicaid program of another state. If the psychiatric
3971 residential treatment facility violates the terms of the written
3972 agreement by admitting or keeping in the facility on a regular or
3973 continuing basis more than thirty (30) patients who are
3974 participating in the Mississippi Medicaid program, the State
3975 Department of Health shall revoke the license of the facility, at
3976 the time that the department determines, after a hearing complying
3977 with due process, that the facility has violated the condition
3978 upon which the certificate of need was issued, as provided in this
3979 paragraph and in the written agreement.

3980 The State Department of Health, on or before July 1, 2002,
3981 shall transfer the certificate of need authorized under the



3982 authority of this paragraph (b), or reissue the certificate of
3983 need if it has expired, to River Region Health System.

3984 (c) Of the total number of beds authorized under this
3985 subsection, the department shall issue a certificate of need to a
3986 hospital currently operating Medicaid-certified acute psychiatric
3987 beds for adolescents in DeSoto County, for the establishment of a
3988 forty-bed psychiatric residential treatment facility in DeSoto
3989 County * * *, ~~provided that the hospital agrees in writing (i)~~
3990 ~~that the hospital shall give priority for the use of those forty~~
3991 ~~(40) beds to Mississippi residents who are presently being treated~~
3992 ~~in out-of-state facilities, and (ii) that no more than fifteen~~
3993 ~~(15) of the beds at the psychiatric residential treatment facility~~
3994 ~~will be certified for participation in the Medicaid program~~
3995 ~~(Section 43-13-101 et seq.), and that no claim will be submitted~~
3996 ~~for Medicaid reimbursement for more than fifteen (15) patients in~~
3997 ~~the psychiatric residential treatment facility in any day or for~~
3998 ~~any patient in the psychiatric residential treatment facility who~~
3999 ~~is in a bed that is not Medicaid-certified. This written~~
4000 ~~agreement by the recipient of the certificate of need shall be a~~
4001 ~~condition of the issuance of the certificate of need under this~~
4002 ~~paragraph, and the agreement shall be fully binding on any~~
4003 ~~subsequent owner of the psychiatric residential treatment facility~~
4004 ~~if the ownership of the facility is transferred at any time after~~
4005 ~~the issuance of the certificate of need. After this written~~
4006 ~~agreement is executed, the Division of Medicaid and the State~~



4007 ~~Department of Health shall not certify more than fifteen (15) of~~
4008 ~~the beds in the psychiatric residential treatment facility for~~
4009 ~~participation in the Medicaid program. If the psychiatric~~
4010 ~~residential treatment facility violates the terms of the written~~
4011 ~~agreement by admitting or keeping in the facility on a regular or~~
4012 ~~continuing basis more than fifteen (15) patients who are~~
4013 ~~participating in the Medicaid program, the State Department of~~
4014 ~~Health shall revoke the license of the facility, at the time that~~
4015 ~~the department determines, after a hearing complying with due~~
4016 ~~process, that the facility has violated the condition upon which~~
4017 ~~the certificate of need was issued, as provided in this paragraph~~
4018 ~~and in the written agreement.~~ There shall be no prohibition or
4019 restrictions on participation in the Medicaid program (Section
4020 43-13-101 et seq.) for the person(s) receiving the certificate of
4021 need authorized under this paragraph (c) or for the beds converted
4022 pursuant to the authority of that certificate of need that would
4023 not apply to any other psychiatric residential treatment facility.

4024 (d) Of the total number of beds authorized under this
4025 subsection, the department may issue a certificate or certificates
4026 of need for the construction or expansion of psychiatric
4027 residential treatment facility beds or the conversion of other
4028 beds to psychiatric treatment facility beds, not to exceed thirty
4029 (30) psychiatric residential treatment facility beds, in either
4030 Alcorn, Tishomingo, Prentiss, Lee, Itawamba, Monroe, Chickasaw,
4031 Pontotoc, Calhoun, Lafayette, Union, Benton or Tippah County.



4032 (e) Of the total number of beds authorized under this
4033 subsection (3) the department shall issue a certificate of need to
4034 a privately owned, nonprofit psychiatric residential treatment
4035 facility in Hinds County for an eight-bed expansion of the
4036 facility, provided that the facility agrees in writing that the
4037 facility shall give priority for the use of those eight (8) beds
4038 to Mississippi residents who are presently being treated in
4039 out-of-state facilities.

4040 (f) The department shall issue a certificate of need to
4041 a one-hundred-thirty-four-bed specialty hospital located on
4042 twenty-nine and forty-four one-hundredths (29.44) commercial acres
4043 at 5900 Highway 39 North in Meridian (Lauderdale County),
4044 Mississippi, for the addition, construction or expansion of
4045 child/adolescent psychiatric residential treatment facility beds
4046 in Lauderdale County. As a condition of issuance of the
4047 certificate of need under this paragraph, the facility shall give
4048 priority in admissions to the child/adolescent psychiatric
4049 residential treatment facility beds authorized under this
4050 paragraph to patients who otherwise would require out-of-state
4051 placement. The Division of Medicaid, in conjunction with the
4052 Department of Human Services, shall furnish the facility a list of
4053 all out-of-state patients on a quarterly basis. Furthermore,
4054 notice shall also be provided to the parent, custodial parent or
4055 guardian of each out-of-state patient notifying them of the
4056 priority status granted by this paragraph. For purposes of this



4057 paragraph, the provisions of Section 41-7-193(1) requiring
4058 substantial compliance with the projection of need as reported in
4059 the current State Health Plan are waived. The total number of
4060 child/adolescent psychiatric residential treatment facility beds
4061 that may be authorized under the authority of this paragraph shall
4062 be sixty (60) beds. There shall be no prohibition or restrictions
4063 on participation in the Medicaid program (Section 43-13-101 et
4064 seq.) for the person receiving the certificate of need authorized
4065 under this paragraph or for the beds converted pursuant to the
4066 authority of that certificate of need.

4067 (4) (a) From and after March 25, 2021, the department may
4068 issue a certificate of need to any person for the new construction
4069 of any hospital, psychiatric hospital or chemical dependency
4070 hospital that will contain any child/adolescent psychiatric or
4071 child/adolescent chemical dependency beds, or for the conversion
4072 of any other health care facility to a hospital, psychiatric
4073 hospital or chemical dependency hospital that will contain any
4074 child/adolescent psychiatric or child/adolescent chemical
4075 dependency beds. There shall be no prohibition or restrictions on
4076 participation in the Medicaid program (Section 43-13-101 et seq.)
4077 for the person(s) receiving the certificate(s) of need authorized
4078 under this paragraph (a) or for the beds converted pursuant to the
4079 authority of that certificate of need. In issuing any new
4080 certificate of need for any child/adolescent psychiatric or
4081 child/adolescent chemical dependency beds, either by new



4082 construction or conversion of beds of another category, the
4083 department shall give preference to beds which will be located in
4084 an area of the state which does not have such beds located in it,
4085 and to a location more than sixty-five (65) miles from existing
4086 beds. Upon receiving 2020 census data, the department may amend
4087 the State Health Plan regarding child/adolescent psychiatric and
4088 child/adolescent chemical dependency beds to reflect the need
4089 based on new census data.

4090 (i) [Deleted]

4091 (ii) The department may issue a certificate of
4092 need for the conversion of existing beds in a county hospital in
4093 Choctaw County from acute care beds to child/adolescent chemical
4094 dependency beds. For purposes of this subparagraph (ii), the
4095 provisions of Section 41-7-193(1) requiring substantial compliance
4096 with the projection of need as reported in the current State
4097 Health Plan are waived. The total number of beds that may be
4098 authorized under authority of this subparagraph shall not exceed
4099 twenty (20) beds. There shall be no prohibition or restrictions
4100 on participation in the Medicaid program (Section 43-13-101 et
4101 seq.) for the hospital receiving the certificate of need
4102 authorized under this subparagraph or for the beds converted
4103 pursuant to the authority of that certificate of need.

4104 (iii) The department may issue a certificate or
4105 certificates of need for the construction or expansion of
4106 child/adolescent psychiatric beds or the conversion of other beds



4107 to child/adolescent psychiatric beds in Warren County. For
4108 purposes of this subparagraph (iii), the provisions of Section
4109 41-7-193(1) requiring substantial compliance with the projection
4110 of need as reported in the current State Health Plan are waived.
4111 The total number of beds that may be authorized under the
4112 authority of this subparagraph shall not exceed twenty (20) beds.
4113 There shall be no prohibition or restrictions on participation in
4114 the Medicaid program (Section 43-13-101 et seq.) for the person
4115 receiving the certificate of need authorized under this
4116 subparagraph or for the beds converted pursuant to the authority
4117 of that certificate of need.

4118 If by January 1, 2002, there has been no significant
4119 commencement of construction of the beds authorized under this
4120 subparagraph (iii), or no significant action taken to convert
4121 existing beds to the beds authorized under this subparagraph, then
4122 the certificate of need that was previously issued under this
4123 subparagraph shall expire. If the previously issued certificate
4124 of need expires, the department may accept applications for
4125 issuance of another certificate of need for the beds authorized
4126 under this subparagraph, and may issue a certificate of need to
4127 authorize the construction, expansion or conversion of the beds
4128 authorized under this subparagraph.

4129 (iv) The department shall issue a certificate of
4130 need to the Region 7 Mental Health/Retardation Commission for the
4131 construction or expansion of child/adolescent psychiatric beds or



4132 the conversion of other beds to child/adolescent psychiatric beds
4133 in any of the counties served by the commission. For purposes of
4134 this subparagraph (iv), the provisions of Section 41-7-193(1)
4135 requiring substantial compliance with the projection of need as
4136 reported in the current State Health Plan are waived. The total
4137 number of beds that may be authorized under the authority of this
4138 subparagraph shall not exceed twenty (20) beds. There shall be no
4139 prohibition or restrictions on participation in the Medicaid
4140 program (Section 43-13-101 et seq.) for the person receiving the
4141 certificate of need authorized under this subparagraph or for the
4142 beds converted pursuant to the authority of that certificate of
4143 need.

4144 (v) The department may issue a certificate of need
4145 to any county hospital located in Leflore County for the
4146 construction or expansion of adult psychiatric beds or the
4147 conversion of other beds to adult psychiatric beds, not to exceed
4148 twenty (20) beds, provided that the recipient of the certificate
4149 of need agrees in writing that the adult psychiatric beds will not
4150 at any time be certified for participation in the Medicaid program
4151 and that the hospital will not admit or keep any patients who are
4152 participating in the Medicaid program in any of such adult
4153 psychiatric beds. This written agreement by the recipient of the
4154 certificate of need shall be fully binding on any subsequent owner
4155 of the hospital if the ownership of the hospital is transferred at
4156 any time after the issuance of the certificate of need. Agreement



4157 that the adult psychiatric beds will not be certified for
4158 participation in the Medicaid program shall be a condition of the
4159 issuance of a certificate of need to any person under this
4160 subparagraph (v), and if such hospital at any time after the
4161 issuance of the certificate of need, regardless of the ownership
4162 of the hospital, has any of such adult psychiatric beds certified
4163 for participation in the Medicaid program or admits or keeps any
4164 Medicaid patients in such adult psychiatric beds, the State
4165 Department of Health shall revoke the certificate of need, if it
4166 is still outstanding, and shall deny or revoke the license of the
4167 hospital at the time that the department determines, after a
4168 hearing complying with due process, that the hospital has failed
4169 to comply with any of the conditions upon which the certificate of
4170 need was issued, as provided in this subparagraph and in the
4171 written agreement by the recipient of the certificate of need.

4172 (vi) The department may issue a certificate or
4173 certificates of need for the expansion of child psychiatric beds
4174 or the conversion of other beds to child psychiatric beds at the
4175 University of Mississippi Medical Center. For purposes of this
4176 subparagraph (vi), the provisions of Section 41-7-193(1) requiring
4177 substantial compliance with the projection of need as reported in
4178 the current State Health Plan are waived. The total number of
4179 beds that may be authorized under the authority of this
4180 subparagraph shall not exceed fifteen (15) beds. There shall be
4181 no prohibition or restrictions on participation in the Medicaid



4182 program (Section 43-13-101 et seq.) for the hospital receiving the
4183 certificate of need authorized under this subparagraph or for the
4184 beds converted pursuant to the authority of that certificate of
4185 need.

4186 (b) From and after July 1, 1990, no hospital,
4187 psychiatric hospital or chemical dependency hospital shall be
4188 authorized to add any child/adolescent psychiatric or
4189 child/adolescent chemical dependency beds or convert any beds of
4190 another category to child/adolescent psychiatric or
4191 child/adolescent chemical dependency beds without a certificate of
4192 need under the authority of subsection (1)(c) and subsection
4193 (4)(a) of this section.

4194 (5) The department may issue a certificate of need to a
4195 county hospital in Winston County for the conversion of fifteen
4196 (15) acute care beds to geriatric psychiatric care beds.

4197 (6) The State Department of Health shall issue a certificate
4198 of need to a Mississippi corporation qualified to manage a
4199 long-term care hospital as defined in Section 41-7-173(h)(xii) in
4200 Harrison County, not to exceed eighty (80) beds, including any
4201 necessary renovation or construction required for licensure and
4202 certification, provided that the recipient of the certificate of
4203 need agrees in writing that the long-term care hospital will not
4204 at any time participate in the Medicaid program (Section 43-13-101
4205 et seq.) * * * ~~or admit or keep any patients in the long-term care~~
4206 ~~hospital who are participating in the Medicaid program~~ except as a



4207 crossover enrolled provider. This written agreement by the
4208 recipient of the certificate of need shall be fully binding on any
4209 subsequent owner of the long-term care hospital, if the ownership
4210 of the facility is transferred at any time after the issuance of
4211 the certificate of need. Agreement that the long-term care
4212 hospital will not participate in the Medicaid program except as a
4213 crossover enrolled provider shall be a condition of the issuance
4214 of a certificate of need to any person under this subsection (6),
4215 and if such long-term care hospital at any time after the issuance
4216 of the certificate of need, regardless of the ownership of the
4217 facility, participates in the Medicaid program * * *~~or admits or~~
4218 ~~keeps any patients in the facility who are participating in the~~
4219 ~~Medicaid program~~ except as a crossover enrolled provider, the
4220 State Department of Health shall revoke the certificate of need,
4221 if it is still outstanding, and shall deny or revoke the license
4222 of the long-term care hospital, at the time that the department
4223 determines, after a hearing complying with due process, that the
4224 facility has failed to comply with any of the conditions upon
4225 which the certificate of need was issued, as provided in this
4226 subsection and in the written agreement by the recipient of the
4227 certificate of need. For purposes of this subsection, the
4228 provisions of Section 41-7-193(1) requiring substantial compliance
4229 with the projection of need as reported in the current State
4230 Health Plan are waived. This subsection (6) shall be retroactive
4231 to July 1, 2023.



4232 (7) The State Department of Health may issue a certificate
4233 of need to any hospital in the state to utilize a portion of its
4234 beds for the "swing-bed" concept. Any such hospital must be in
4235 conformance with the federal regulations regarding such swing-bed
4236 concept at the time it submits its application for a certificate
4237 of need to the State Department of Health, except that such
4238 hospital may have more licensed beds or a higher average daily
4239 census (ADC) than the maximum number specified in federal
4240 regulations for participation in the swing-bed program. Any
4241 hospital meeting all federal requirements for participation in the
4242 swing-bed program which receives such certificate of need shall
4243 render services provided under the swing-bed concept to any
4244 patient eligible for Medicare (Title XVIII of the Social Security
4245 Act) who is certified by a physician to be in need of such
4246 services, and no such hospital shall permit any patient who is
4247 eligible for both Medicaid and Medicare or eligible only for
4248 Medicaid to stay in the swing beds of the hospital for more than
4249 thirty (30) days per admission unless the hospital receives prior
4250 approval for such patient from the Division of Medicaid, Office of
4251 the Governor. Any hospital having more licensed beds or a higher
4252 average daily census (ADC) than the maximum number specified in
4253 federal regulations for participation in the swing-bed program
4254 which receives such certificate of need shall develop a procedure
4255 to ensure that before a patient is allowed to stay in the swing
4256 beds of the hospital, there are no vacant nursing home beds



4257 available for that patient located within a fifty-mile radius of
4258 the hospital. When any such hospital has a patient staying in the
4259 swing beds of the hospital and the hospital receives notice from a
4260 nursing home located within such radius that there is a vacant bed
4261 available for that patient, the hospital shall transfer the
4262 patient to the nursing home within a reasonable time after receipt
4263 of the notice. Any hospital which is subject to the requirements
4264 of the two (2) preceding sentences of this subsection may be
4265 suspended from participation in the swing-bed program for a
4266 reasonable period of time by the State Department of Health if the
4267 department, after a hearing complying with due process, determines
4268 that the hospital has failed to comply with any of those
4269 requirements.

4270 (8) The Department of Health shall not grant approval for or
4271 issue a certificate of need to any person proposing the new
4272 construction of, addition to or expansion of a health care
4273 facility as defined in subparagraph (viii) of Section 41-7-173(h),
4274 except as hereinafter provided: The department may issue a
4275 certificate of need to a nonprofit corporation located in Madison
4276 County, Mississippi, for the construction, expansion or conversion
4277 of not more than twenty (20) beds in a community living program
4278 for developmentally disabled adults in a facility as defined in
4279 subparagraph (viii) of Section 41-7-173(h). For purposes of this
4280 subsection (8), the provisions of Section 41-7-193(1) requiring
4281 substantial compliance with the projection of need as reported in



4282 the current State Health Plan and the provisions of Section
4283 41-7-197 requiring a formal certificate of need hearing process
4284 are waived. There shall be no prohibition or restrictions on
4285 participation in the Medicaid program for the person receiving the
4286 certificate of need authorized under this subsection (8).

4287 (9) The Department of Health shall not grant approval for or
4288 issue a certificate of need to any person proposing the
4289 establishment of, or expansion of the currently approved territory
4290 of, or the contracting to establish a home office, subunit or
4291 branch office within the space operated as a health care facility
4292 as defined in Section 41-7-173(h) (i) through (viii) by a health
4293 care facility as defined in subparagraph (ix) of Section
4294 41-7-173(h).

4295 (10) Health care facilities owned and/or operated by the
4296 state or its agencies are exempt from the restraints in this
4297 section against issuance of a certificate of need if such addition
4298 or expansion consists of repairing or renovation necessary to
4299 comply with the state licensure law. This exception shall not
4300 apply to the new construction of any building by such state
4301 facility. This exception shall not apply to any health care
4302 facilities owned and/or operated by counties, municipalities,
4303 districts, unincorporated areas, other defined persons, or any
4304 combination thereof.

4305 (11) The new construction, renovation or expansion of or
4306 addition to any health care facility defined in subparagraph (ii)



4307 (psychiatric hospital), subparagraph (iv) (skilled nursing
4308 facility), subparagraph (vi) (intermediate care facility),
4309 subparagraph (viii) (intermediate care facility for individuals
4310 with intellectual disabilities) and subparagraph (x) (psychiatric
4311 residential treatment facility) of Section 41-7-173(h) which is
4312 owned by the State of Mississippi and under the direction and
4313 control of the State Department of Mental Health, and the addition
4314 of new beds or the conversion of beds from one category to another
4315 in any such defined health care facility which is owned by the
4316 State of Mississippi and under the direction and control of the
4317 State Department of Mental Health, shall not require the issuance
4318 of a certificate of need under Section 41-7-171 et seq.,
4319 notwithstanding any provision in Section 41-7-171 et seq. to the
4320 contrary.

4321 (12) The new construction, renovation or expansion of or
4322 addition to any veterans homes or domiciliaries for eligible
4323 veterans of the State of Mississippi as authorized under Section
4324 35-1-19 shall not require the issuance of a certificate of need,
4325 notwithstanding any provision in Section 41-7-171 et seq. to the
4326 contrary.

4327 (13) The repair or the rebuilding of an existing, operating
4328 health care facility that sustained significant damage from a
4329 natural disaster that occurred after April 15, 2014, in an area
4330 that is proclaimed a disaster area or subject to a state of
4331 emergency by the Governor or by the President of the United States



4332 shall be exempt from all of the requirements of the Mississippi
4333 Certificate of Need Law (Section 41-7-171 et seq.) and any and all
4334 rules and regulations promulgated under that law, subject to the
4335 following conditions:

4336 (a) The repair or the rebuilding of any such damaged
4337 health care facility must be within one (1) mile of the
4338 pre-disaster location of the campus of the damaged health care
4339 facility, except that any temporary post-disaster health care
4340 facility operating location may be within five (5) miles of the
4341 pre-disaster location of the damaged health care facility;

4342 (b) The repair or the rebuilding of the damaged health
4343 care facility (i) does not increase or change the complement of
4344 its bed capacity that it had before the Governor's or the
4345 President's proclamation, (ii) does not increase or change its
4346 levels and types of health care services that it provided before
4347 the Governor's or the President's proclamation, and (iii) does not
4348 rebuild in a different county; however, this paragraph does not
4349 restrict or prevent a health care facility from decreasing its bed
4350 capacity that it had before the Governor's or the President's
4351 proclamation, or from decreasing the levels of or decreasing or
4352 eliminating the types of health care services that it provided
4353 before the Governor's or the President's proclamation, when the
4354 damaged health care facility is repaired or rebuilt;

4355 (c) The exemption from Certificate of Need Law provided
4356 under this subsection (13) is valid for only five (5) years from



4357 the date of the Governor's or the President's proclamation. If
4358 actual construction has not begun within that five-year period,
4359 the exemption provided under this subsection is inapplicable; and

4360 (d) The Division of Health Facilities Licensure and
4361 Certification of the State Department of Health shall provide the
4362 same oversight for the repair or the rebuilding of the damaged
4363 health care facility that it provides to all health care facility
4364 construction projects in the state.

4365 For the purposes of this subsection (13), "significant
4366 damage" to a health care facility means damage to the health care
4367 facility requiring an expenditure of at least One Million Dollars
4368 (\$1,000,000.00).

4369 (14) The State Department of Health shall issue a
4370 certificate of need to any hospital which is currently licensed
4371 for two hundred fifty (250) or more acute care beds and is located
4372 in any general hospital service area not having a comprehensive
4373 cancer center, for the establishment and equipping of such a
4374 center which provides facilities and services for outpatient
4375 radiation oncology therapy, outpatient medical oncology therapy,
4376 and appropriate support services including the provision of
4377 radiation therapy services. The provisions of Section 41-7-193(1)
4378 regarding substantial compliance with the projection of need as
4379 reported in the current State Health Plan are waived for the
4380 purpose of this subsection.



4381 (15) The State Department of Health may authorize the
4382 transfer of hospital beds, not to exceed sixty (60) beds, from the
4383 North Panola Community Hospital to the South Panola Community
4384 Hospital. The authorization for the transfer of those beds shall
4385 be exempt from the certificate of need review process.

4386 (16) The State Department of Health shall issue any
4387 certificates of need necessary for Mississippi State University
4388 and a public or private health care provider to jointly acquire
4389 and operate a linear accelerator and a magnetic resonance imaging
4390 unit. Those certificates of need shall cover all capital
4391 expenditures related to the project between Mississippi State
4392 University and the health care provider, including, but not
4393 limited to, the acquisition of the linear accelerator, the
4394 magnetic resonance imaging unit and other radiological modalities;
4395 the offering of linear accelerator and magnetic resonance imaging
4396 services; and the cost of construction of facilities in which to
4397 locate these services. The linear accelerator and the magnetic
4398 resonance imaging unit shall be (a) located in the City of
4399 Starkville, Oktibbeha County, Mississippi; (b) operated jointly by
4400 Mississippi State University and the public or private health care
4401 provider selected by Mississippi State University through a
4402 request for proposals (RFP) process in which Mississippi State
4403 University selects, and the Board of Trustees of State
4404 Institutions of Higher Learning approves, the health care provider
4405 that makes the best overall proposal; (c) available to Mississippi



4406 State University for research purposes two-thirds (2/3) of the
4407 time that the linear accelerator and magnetic resonance imaging
4408 unit are operational; and (d) available to the public or private
4409 health care provider selected by Mississippi State University and
4410 approved by the Board of Trustees of State Institutions of Higher
4411 Learning one-third (1/3) of the time for clinical, diagnostic and
4412 treatment purposes. For purposes of this subsection, the
4413 provisions of Section 41-7-193(1) requiring substantial compliance
4414 with the projection of need as reported in the current State
4415 Health Plan are waived.

4416 (17) The State Department of Health shall issue a
4417 certificate of need for the construction of an acute care hospital
4418 in Kemper County, not to exceed twenty-five (25) beds, which shall
4419 be named the "John C. Stennis Memorial Hospital." In issuing the
4420 certificate of need under this subsection, the department shall
4421 give priority to a hospital located in Lauderdale County that has
4422 two hundred fifteen (215) beds. For purposes of this subsection,
4423 the provisions of Section 41-7-193(1) requiring substantial
4424 compliance with the projection of need as reported in the current
4425 State Health Plan and the provisions of Section 41-7-197 requiring
4426 a formal certificate of need hearing process are waived. There
4427 shall be no prohibition or restrictions on participation in the
4428 Medicaid program (Section 43-13-101 et seq.) for the person or
4429 entity receiving the certificate of need authorized under this



4430 subsection or for the beds constructed under the authority of that
4431 certificate of need.

4432 (18) The planning, design, construction, renovation,
4433 addition, furnishing and equipping of a clinical research unit at
4434 any health care facility defined in Section 41-7-173(h) that is
4435 under the direction and control of the University of Mississippi
4436 Medical Center and located in Jackson, Mississippi, and the
4437 addition of new beds or the conversion of beds from one (1)
4438 category to another in any such clinical research unit, shall not
4439 require the issuance of a certificate of need under Section
4440 41-7-171 et seq., notwithstanding any provision in Section
4441 41-7-171 et seq. to the contrary.

4442 (19) [Repealed]

4443 (20) Nothing in this section or in any other provision of
4444 Section 41-7-171 et seq. shall prevent any nursing facility from
4445 designating an appropriate number of existing beds in the facility
4446 as beds for providing care exclusively to patients with
4447 Alzheimer's disease.

4448 (21) Nothing in this section or any other provision of
4449 Section 41-7-171 et seq. shall prevent any health care facility
4450 from the new construction, renovation, conversion or expansion of
4451 new beds in the facility designated as intensive care units,
4452 negative pressure rooms, or isolation rooms pursuant to the
4453 provisions of Sections 41-14-1 through 41-14-11, or Section
4454 41-14-31. For purposes of this subsection, the provisions of



4455 Section 41-7-193(1) requiring substantial compliance with the
4456 projection of need as reported in the current State Health Plan
4457 and the provisions of Section 41-7-197 requiring a formal
4458 certificate of need hearing process are waived.

4459 **SECTION 14.** The following shall be codified as Section
4460 83-9-47, Mississippi Code of 1972:

4461 83-9-47. (1) An insurer providing coverage for prescription
4462 drugs shall not require or impose any step therapy protocol with
4463 respect to a drug that is approved by the United States Food and
4464 Drug Administration for the treatment of postpartum depression.

4465 (2) As used in this section, "insurer" means any hospital,
4466 health or medical expense insurance policy, hospital or medical
4467 service contract, employee welfare benefit plan, contract or
4468 agreement with a health maintenance organization or a preferred
4469 provider organization, health and accident insurance policy, or
4470 any other insurance contract of this type, including a group
4471 insurance plan. However, the term "insurer" does not include a
4472 preferred provider organization that is only a network of
4473 providers and does not define health care benefits for the purpose
4474 of coverage under a health care benefits plan.

4475 **SECTION 15.** The following shall be codified as Section
4476 41-140-1, Mississippi Code of 1972:

4477 41-140-1. **Definitions.** (1) "Maternal health care facility"
4478 means any facility that provides prenatal or perinatal care,



4479 including, but not limited to, hospitals, clinics and other
4480 physician facilities.

4481 (2) "Maternal health care provider" means any physician,
4482 nurse or other authorized practitioner that attends to pregnant
4483 women and mothers of infants.

4484 **SECTION 16.** The following shall be codified as Section
4485 41-140-3, Mississippi Code of 1972:

4486 41-140-3. **Education and awareness.** (1) The State
4487 Department of Health shall develop written educational materials
4488 and information for health care professionals and patients about
4489 maternal mental health conditions, including postpartum
4490 depression.

4491 (a) The materials shall include information on the
4492 symptoms and methods of coping with postpartum depression, as well
4493 treatment options and resources;

4494 (b) The State Department of Health shall periodically
4495 review the materials and information to determine their
4496 effectiveness and ensure they reflect the most up-to-date and
4497 accurate information;

4498 (c) The State Department of Health shall post on its
4499 website the materials and information; and

4500 (d) The State Department of Health shall make available
4501 or distribute the materials and information in physical form upon
4502 request.



4503 (2) Hospitals that provide birth services shall provide
4504 departing new parents and other family members, as appropriate,
4505 with written materials and information developed under subsection
4506 (1) of this section, upon discharge from such institution.

4507 (3) Any facility, physician, health care provider or nurse
4508 midwife who renders prenatal care, postnatal care, or pediatric
4509 infant care, shall provide the materials and information developed
4510 under subsection (1)(a) of this section, to any woman who presents
4511 with signs of a maternal mental health disorder.

4512 **SECTION 17.** The following shall be codified as Section
4513 41-140-5, Mississippi Code of 1972:

4514 41-140-5. **Screening and linkage to care.** (1) Any
4515 physician, health care provider, or nurse midwife who renders
4516 postnatal care or who provides pediatric infant care shall ensure
4517 that the postnatal care patient or birthing mother of the
4518 pediatric infant care patient, as applicable, is offered screening
4519 for postpartum depression, and, if such patient or birthing mother
4520 does not object to such screening, shall ensure that such patient
4521 or birthing mother is appropriately screened for postpartum
4522 depression in line with evidence-based guidelines, such as the
4523 Bright Futures Toolkit developed by the American Academy of
4524 Pediatrics.

4525 (2) If a health care provider administering screening in
4526 accordance with this section determines, based on the screening
4527 methodology administered, that the postnatal care patient or



4528 birthing mother of the pediatric infant care patient is likely to
4529 be suffering from postpartum depression, such health care provider
4530 shall provide appropriate referrals, including discussion of
4531 available treatments for postpartum depression, including
4532 pharmacological treatments.

4533 **SECTION 18.** The following shall be codified as Section
4534 83-9-48, Mississippi Code of 1972:

4535 83-9-48. **Coverage of screening for postpartum depression.**

4536 (1) An insurer shall provide coverage for postpartum depression
4537 screening required pursuant to Section 41-140-3. Such coverage
4538 shall provide for additional reimbursement for the administration
4539 of postpartum depression screening adequate to compensate the
4540 health care provider for the provision of such screening and
4541 consistent with ensuring broad access to postpartum depression
4542 screening in line with evidence-based guidelines.

4543 (2) As used in this section, "insurer" means any hospital,
4544 health or medical expense insurance policy, hospital or medical
4545 service contract, employee welfare benefit plan, contract or
4546 agreement with a health maintenance organization or a preferred
4547 provider organization, health and accident insurance policy, or
4548 any other insurance contract of this type, including a group
4549 insurance plan. However, the term "insurer" does not include a
4550 preferred provider organization that is only a network of
4551 providers and does not define health care benefits for the purpose
4552 of coverage under a health care benefits plan.



4553 **SECTION 19.** This act shall take effect and be in force from
4554 and after its passage.