

By: Senator(s) Blackwell

To: Medicaid

SENATE BILL NO. 2867

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



35 FOR ALTERNATIVE METHODS FOR THE REDUCTION OF SNORING AND
36 OBSTRUCTIVE SLEEP APNEA; TO INCLUDE ADDITIONAL LICENSED PROVIDERS
37 IN THE DIVISION'S UPPER PAYMENT LIMITS PROGRAM; TO AUTHORIZE THAT
38 THE DIVISION MAY, IN CONSULTATION WITH THE MISSISSIPPI HOSPITAL
39 ASSOCIATION, DEVELOP ALTERNATIVE MODELS FOR DISTRIBUTION OF
40 MEDICAL CLAIMS AND SUPPLEMENTAL PAYMENTS FOR INPATIENT AND
41 OUTPATIENT HOSPITAL SERVICES; TO PROVIDE THAT THE DIVISION MAY, TO
42 THE FULLEST EXTENT FEASIBLE, REPLACE THE ADDITIONAL REIMBURSEMENT
43 FOR HOSPITAL INPATIENT SERVICES UNDER THE INPATIENT MEDICARE UPPER
44 PAYMENT LIMITS (UPL) PROGRAM WITH ADDITIONAL REIMBURSEMENT UNDER
45 THE MHAP AND OTHER PAYMENT PROGRAMS; TO DELETE TECHNICAL
46 PROVISIONS RELATED TO THE MISSISSIPPI HOSPITAL ACCESS PROGRAM
47 (MHAP); TO PROVIDE THAT SUPPLEMENTAL PAYMENTS TO A HOSPITAL SHALL
48 NOT DECREASE BY MORE THAN 5% WHEN COMPARED TO A HOSPITAL'S PRIOR
49 YEAR PAYMENT UNLESS THAT HOSPITAL HAS CLOSED, OR CHANGED SERVICES
50 OR PATIENT VOLUME WHICH IMPACTS THAT HOSPITAL'S PAYMENT, AND THE
51 DIVISION SHALL NOT SUBSTANTIALLY CHANGE THE METHODOLOGIES USED TO
52 CALCULATE A HOSPITAL'S SUPPLEMENTAL PAYMENT; TO PROVIDE THAT THE
53 DIVISION SHALL CONTRACT WITH THE STATE DEPARTMENT OF HEALTH TO
54 PROVIDE FOR A PERINATAL HIGH RISK MANAGEMENT/INFANT SERVICES
55 SYSTEM FOR ANY ELIGIBLE BENEFICIARY THAT CANNOT RECEIVE SUCH
56 SERVICES UNDER A DIFFERENT PROGRAM; TO AUTHORIZE THE DIVISION TO
57 REIMBURSE FOR SERVICES AT CERTIFIED COMMUNITY BEHAVIORAL HEALTH
58 CENTERS; TO EXTEND THE DATE OF REPEAL ON THE PROVISION OF LAW THAT
59 PROVIDES THAT THE DIVISION SHALL REIMBURSE FOR OUTPATIENT HOSPITAL
60 SERVICES PROVIDED TO ELIGIBLE MEDICAID BENEFICIARIES UNDER THE AGE
61 OF 21 BY BORDER CITY UNIVERSITY AFFILIATED PEDIATRIC TEACHING
62 HOSPITALS, WHICH WAS REPEALED BY OPERATION OF LAW IN 2024; TO
63 REQUIRE THE DIVISION TO DEVELOP AND IMPLEMENT A METHOD FOR
64 REIMBURSEMENT OF AUTISM SPECTRUM DISORDER SERVICES BASED ON A
65 CONTINUUM OF CARE FOR BEST PRACTICES IN MEDICALLY NECESSARY EARLY
66 INTERVENTION TREATMENT; TO REDUCE THE LENGTH OF NOTICE THE
67 DIVISION MUST PROVIDE THE MEDICAID COMMITTEE CHAIRMEN FOR PROPOSED
68 RATE CHANGES AND TO PROVIDE THAT SUCH LEGISLATIVE NOTICE MAY BE
69 EXPEDITED; TO PROVIDE THAT THE DIVISION SHALL REIMBURSE FOR
70 PREPARTICIPATION PHYSICAL EVALUATIONS; TO PROVIDE THAT THE
71 DIVISION SHALL REIMBURSE FOR UNITED STATES FOOD AND DRUG
72 ADMINISTRATION APPROVED GLUCAGON-LIKE PEPTIDE-1 (GLP-1) AGONIST
73 MEDICATIONS FOR CHRONIC WEIGHT MANAGEMENT OR FOR ADDITIONAL
74 CONDITIONS IN THE DISCRETION OF THE MEDICAL PROVIDER; TO PROHIBIT
75 THE DIVISION OF MEDICAID AND CERTAIN MANAGED CARE ENTITIES FROM
76 REQUIRING OR IMPOSING ANY STEP THERAPY PROTOCOL WITH RESPECT TO A
77 DRUG THAT IS APPROVED BY THE UNITED STATES FDA FOR THE TREATMENT
78 OF POSTPARTUM DEPRESSION; TO REQUIRE THE DIVISION TO PROVIDE
79 COVERAGE AND REIMBURSEMENT FOR POSTPARTUM DEPRESSION SCREENING; TO
80 EXTEND THE DATE OF REPEAL ON SUCH SECTION; TO AMEND SECTION
81 43-13-121, MISSISSIPPI CODE OF 1972, TO REDUCE THE LENGTH OF
82 NOTICE THE DIVISION MUST PROVIDE THE MEDICAID COMMITTEE CHAIRMEN
83 FOR A PROPOSED STATE PLAN AMENDMENT AND TO PROVIDE THAT SUCH
84 LEGISLATIVE NOTICE MAY BE EXPEDITED; TO AMEND SECTION 43-13-305,
85 MISSISSIPPI CODE OF 1972, TO REVISE CERTAIN PROVISIONS RELATED TO



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



137 POSTNATAL CARE PATIENT OR BIRTHING MOTHER OF THE PEDIATRIC INFANT
138 CARE PATIENT, AS APPLICABLE, IS OFFERED SCREENING FOR POSTPARTUM
139 DEPRESSION AND TO PROVIDE APPROPRIATE REFERRALS IF SUCH PATIENT OR
140 MOTHER IS DEEMED LIKELY TO BE SUFFERING FROM POSTPARTUM
141 DEPRESSION; TO CREATE NEW SECTION 83-9-48, MISSISSIPPI CODE OF
142 1972, TO DEFINE "INSURER" AND REQUIRE INSURERS TO PROVIDE COVERAGE
143 FOR POSTPARTUM DEPRESSION SCREENING; AND FOR RELATED PURPOSES.

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

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

147 43-13-115. Recipients of Medicaid shall be the following
148 persons only:

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



165 1931 of the federal Social Security Act and shall redetermine
166 eligibility for those continuing under Title IV-A grants.

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

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

178 (4) [Deleted]

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



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

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

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



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

216 (9) Individuals who are:

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

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

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

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

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



239 the federal Social Security Act, as amended. The eligibility of
240 individuals under this paragraph shall be determined by the
241 Division of Medicaid.

242 (11) * * * ~~Until the end of the day on December 31,~~
243 ~~2005,~~ Individuals who are sixty-five (65) years of age or older
244 or are disabled as determined under Section 1614(a)(3) of the
245 federal Social Security Act, as amended, and whose income does not
246 exceed one hundred thirty-five percent (135%) of the * * * ~~nonfarm~~
247 ~~official poverty level as defined by the Office of Management and~~
248 ~~Budget and revised annually~~ federal poverty level, and whose
249 resources do not exceed those established by the Division of
250 Medicaid. The eligibility of individuals covered under this
251 paragraph shall be determined by the Division of Medicaid. * * *
252 ~~After December 31, 2005,~~ Only those individuals covered under the
253 1115(c) Healthier Mississippi waiver will be covered under this
254 category.

255 Any individual who applied for Medicaid during the period
256 from July 1, 2004, through March 31, 2005, who otherwise would
257 have been eligible for coverage under this paragraph (11) if it
258 had been in effect at the time the individual submitted his or her
259 application and is still eligible for coverage under this
260 paragraph (11) on March 31, 2005, shall be eligible for Medicaid
261 coverage under this paragraph (11) from March 31, 2005, through
262 December 31, 2005. The division shall give priority in processing



263 the applications for those individuals to determine their
264 eligibility under this paragraph (11).

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

272 The eligibility of individuals covered under this paragraph
273 shall be determined by the Division of Medicaid, and those
274 individuals determined eligible shall receive Medicare
275 cost-sharing expenses only as more fully defined by the Medicare
276 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
277 1997.

278 (13) (a) Individuals who are entitled to Medicare Part
279 A as defined in Section 4501 of the Omnibus Budget Reconciliation
280 Act of 1990, and whose income does not exceed one hundred twenty
281 percent (120%) of the * * *~~nonfarm official poverty level as~~
282 ~~defined by the Office of Management and Budget and revised~~
283 ~~annually~~ federal poverty level. Eligibility for Medicaid benefits
284 is limited to full payment of Medicare Part B premiums.

285 (b) Individuals entitled to Part A of Medicare,
286 with income above one hundred twenty percent (120%), but less than
287 one hundred thirty-five percent (135%) of the federal poverty



288 level, and not otherwise eligible for Medicaid. Eligibility for
289 Medicaid benefits is limited to full payment of Medicare Part B
290 premiums. The number of eligible individuals is limited by the
291 availability of the federal capped allocation at one hundred
292 percent (100%) of federal matching funds, as more fully defined in
293 the Balanced Budget Act of 1997.

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

296 (14) [Deleted]

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

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



312 (17) In accordance with the terms of the federal
313 Personal Responsibility and Work Opportunity Reconciliation Act of
314 1996 (Public Law 104-193), persons who become ineligible for
315 assistance under Title IV-A of the federal Social Security Act, as
316 amended, because of increased income from or hours of employment
317 of the caretaker relative or because of the expiration of the
318 applicable earned income disregards, who were eligible for
319 Medicaid for at least three (3) of the six (6) months preceding
320 the month in which the ineligibility begins, shall be eligible for
321 Medicaid for up to twelve (12) months. The eligibility of the
322 individuals covered under this paragraph shall be determined by
323 the division.

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

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



337 (250%) of the federal poverty level, shall be allowed to purchase
338 Medicaid coverage on a sliding fee scale developed by the Division
339 of Medicaid.

340 (20) Medicaid eligible children under age eighteen (18)
341 shall remain eligible for Medicaid benefits until the end of a
342 period of twelve (12) months following an eligibility
343 determination, or until such time that the individual exceeds age
344 eighteen (18).

345 (21) Women and men of * * * ~~childbearing~~ reproductive
346 age whose family income does not exceed * * * ~~one hundred~~
347 ~~eighty-five percent (185%)~~ one hundred ninety-four percent (194%)
348 of the federal poverty level. The eligibility of individuals
349 covered under this paragraph (21) shall be determined by the
350 Division of Medicaid, and those individuals determined eligible
351 shall only receive family planning services covered under Section
352 43-13-117(13) and not any other services covered under Medicaid.
353 However, any individual eligible under this paragraph (21) who is
354 also eligible under any other provision of this section shall
355 receive the benefits to which he or she is entitled under that
356 other provision, in addition to family planning services covered
357 under Section 43-13-117(13).

358 The Division of Medicaid * * * ~~shall~~ may apply to the United
359 States Secretary of Health and Human Services for a federal waiver
360 of the applicable provisions of Title XIX of the federal Social
361 Security Act, as amended, and any other applicable provisions of



362 federal law as necessary to allow for the implementation of this
363 paragraph (21). * * * ~~The provisions of this paragraph (21) shall~~
364 ~~be implemented from and after the date that the Division of~~
365 ~~Medicaid receives the federal waiver.~~

366 (22) Persons who are workers with a potentially severe
367 disability, as determined by the division, shall be allowed to
368 purchase Medicaid coverage. The term "worker with a potentially
369 severe disability" means a person who is at least sixteen (16)
370 years of age but under sixty-five (65) years of age, who has a
371 physical or mental impairment that is reasonably expected to cause
372 the person to become blind or disabled as defined under Section
373 1614(a) of the federal Social Security Act, as amended, if the
374 person does not receive items and services provided under
375 Medicaid.

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

383 (23) Children certified by the Mississippi Department
384 of Human Services for whom the state and county departments of
385 human services have custody and financial responsibility who are
386 in foster care on their eighteenth birthday as reported by the



387 Mississippi Department of Human Services shall be certified
388 Medicaid eligible by the Division of Medicaid until their * * *
389 ~~twenty-first~~ twenty-sixth birthday. Children who have aged out of
390 foster care while on Medicaid in other states shall qualify until
391 their twenty-sixth birthday.

392 (24) Individuals who have not attained age sixty-five
393 (65), are not otherwise covered by creditable coverage as defined
394 in the Public Health Services Act, and have been screened for
395 breast and cervical cancer under the Centers for Disease Control
396 and Prevention Breast and Cervical Cancer Early Detection Program
397 established under Title XV of the Public Health Service Act in
398 accordance with the requirements of that act and who need
399 treatment for breast or cervical cancer. Eligibility of
400 individuals under this paragraph (24) shall be determined by the
401 Division of Medicaid.

402 (25) The division shall apply to the Centers for
403 Medicare and Medicaid Services (CMS) for any necessary waivers to
404 provide services to individuals who are sixty-five (65) years of
405 age or older or are disabled as determined under Section
406 1614(a)(3) of the federal Social Security Act, as amended, and
407 whose income does not exceed one hundred thirty-five percent
408 (135%) of the * * * ~~nonfarm official poverty level as defined by~~
409 ~~the Office of Management and Budget and revised annually~~ federal
410 poverty level, and whose resources do not exceed those established
411 by the Division of Medicaid, and who are not otherwise covered by



412 Medicare. Nothing contained in this paragraph (25) shall entitle
413 an individual to benefits. The eligibility of individuals covered
414 under this paragraph shall be determined by the Division of
415 Medicaid.

416 (26) * * * ~~The division shall apply to the Centers for~~
417 ~~Medicare and Medicaid Services (CMS) for any necessary waivers to~~
418 ~~provide services to individuals who are sixty-five (65) years of~~
419 ~~age or older or are disabled as determined under Section~~
420 ~~1614(a)(3) of the federal Social Security Act, as amended, who are~~
421 ~~end stage renal disease patients on dialysis, cancer patients on~~
422 ~~chemotherapy or organ transplant recipients on antirejection~~
423 ~~drugs, whose income does not exceed one hundred thirty-five~~
424 ~~percent (135%) of the nonfarm official poverty level as defined by~~
425 ~~the Office of Management and Budget and revised annually, and~~
426 ~~whose resources do not exceed those established by the division.~~
427 ~~Nothing contained in this paragraph (26) shall entitle an~~
428 ~~individual to benefits. The eligibility of individuals covered~~
429 ~~under this paragraph shall be determined by the Division of~~
430 ~~Medicaid. [Deleted]~~

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



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

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

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

447 43-13-117. (A) Medicaid as authorized by this article shall
448 include payment of part or all of the costs, at the discretion of
449 the division, with approval of the Governor and the Centers for
450 Medicare and Medicaid Services, of the following types of care and
451 services rendered to eligible applicants who have been determined
452 to be eligible for that care and services, within the limits of
453 state appropriations and federal matching funds:

454 (1) Inpatient hospital services.

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

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



462 (H) of this section unless specifically authorized by the
463 division.

464 (2) Outpatient hospital services.

465 (a) Emergency services.

466 (b) Other outpatient hospital services. The
467 division shall allow benefits for other medically necessary
468 outpatient hospital services (such as chemotherapy, radiation,
469 surgery and therapy), including outpatient services in a clinic or
470 other facility that is not located inside the hospital, but that
471 has been designated as an outpatient facility by the hospital, and
472 that was in operation or under construction on July 1, 2009,
473 provided that the costs and charges associated with the operation
474 of the hospital clinic are included in the hospital's cost report.
475 In addition, the Medicare thirty-five-mile rule will apply to
476 those hospital clinics not located inside the hospital that are
477 constructed after July 1, 2009. Where the same services are
478 reimbursed as clinic services, the division may revise the rate or
479 methodology of outpatient reimbursement to maintain consistency,
480 efficiency, economy and quality of care.

481 (c) The division is authorized to implement an
482 Ambulatory Payment Classification (APC) methodology for outpatient
483 hospital services. * * * ~~The division shall give rural hospitals~~
484 ~~that have fifty (50) or fewer licensed beds the option to not be~~
485 ~~reimbursed for outpatient hospital services using the APC~~
486 ~~methodology, but reimbursement for outpatient hospital services~~



487 ~~provided by those hospitals shall be based on one hundred one~~
488 ~~percent (101%) of the rate established under Medicare for~~
489 ~~outpatient hospital services. Those hospitals choosing to not be~~
490 ~~reimbursed under the APC methodology shall remain under cost-based~~
491 ~~reimbursement for a two-year period.~~

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

497 (3) Laboratory and x-ray services.

498 (4) Nursing facility services.

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

506 (b) From and after July 1, 1997, the division
507 shall implement the integrated case-mix payment and quality
508 monitoring system, which includes the fair rental system for
509 property costs and in which recapture of depreciation is
510 eliminated. The division may reduce the payment for hospital
511 leave and therapeutic home leave days to the lower of the case-mix



512 category as computed for the resident on leave using the
513 assessment being utilized for payment at that point in time, or a
514 case-mix score of 1.000 for nursing facilities, and shall compute
515 case-mix scores of residents so that only services provided at the
516 nursing facility are considered in calculating a facility's per
517 diem.

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

521 (d) * * * ~~On or after January 1, 2015,~~ The
522 division shall update the case-mix payment system * * * ~~resource~~
523 ~~utilization grouper and classifications~~ and fair rental
524 reimbursement system as necessary to maintain compliance with
525 federal law. The division shall develop and implement a payment
526 add-on to reimburse nursing facilities for ventilator-dependent
527 resident services.

528 (e) The division shall develop and implement, not
529 later than January 1, 2001, a case-mix payment add-on determined
530 by time studies and other valid statistical data that will
531 reimburse a nursing facility for the additional cost of caring for
532 a resident who has a diagnosis of Alzheimer's or other related
533 dementia and exhibits symptoms that require special care. Any
534 such case-mix add-on payment shall be supported by a determination
535 of additional cost. The division shall also develop and implement
536 as part of the fair rental reimbursement system for nursing



537 facility beds, an Alzheimer's resident bed depreciation enhanced
538 reimbursement system that will provide an incentive to encourage
539 nursing facilities to convert or construct beds for residents with
540 Alzheimer's or other related dementia.

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

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

547 The division shall apply for necessary federal waivers to
548 assure that additional services providing alternatives to nursing
549 facility care are made available to applicants for nursing
550 facility care.

551 (5) Periodic screening and diagnostic services for
552 individuals under age twenty-one (21) years as are needed to
553 identify physical and mental defects and to provide health care
554 treatment and other measures designed to correct or ameliorate
555 defects and physical and mental illness and conditions discovered
556 by the screening services, regardless of whether these services
557 are included in the state plan. The division may include in its
558 periodic screening and diagnostic program those discretionary
559 services authorized under the federal regulations adopted to
560 implement Title XIX of the federal Social Security Act, as
561 amended. The division, in obtaining physical therapy services,



562 occupational therapy services, and services for individuals with
563 speech, hearing and language disorders, may enter into a
564 cooperative agreement with the State Department of Education for
565 the provision of those services to handicapped students by public
566 school districts using state funds that are provided from the
567 appropriation to the Department of Education to obtain federal
568 matching funds through the division. The division, in obtaining
569 medical and mental health assessments, treatment, care and
570 services for children who are in, or at risk of being put in, the
571 custody of the Mississippi Department of Human Services may enter
572 into a cooperative agreement with the Mississippi Department of
573 Human Services for the provision of those services using state
574 funds that are provided from the appropriation to the Department
575 of Human Services to obtain federal matching funds through the
576 division.

577 (6) Physician services. Fees for physician's services
578 that are covered only by Medicaid shall be reimbursed at ninety
579 percent (90%) of the rate established on January 1, 2018, and as
580 may be adjusted each July thereafter, under Medicare. The
581 division may provide for a reimbursement rate for physician's
582 services of up to one hundred percent (100%) of the rate
583 established under Medicare for physician's services that are
584 provided after the normal working hours of the physician, as
585 determined in accordance with regulations of the division. The
586 division may reimburse eligible providers, as determined by the



587 division, for certain primary care services at one hundred percent
588 (100%) of the rate established under Medicare. The division shall
589 reimburse obstetricians * * * ~~and,~~ gynecologists and pediatricians
590 for certain primary care services as defined by the division at
591 one hundred percent (100%) of the rate established under Medicare.

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

602 (b) [Repealed]

603 (8) Emergency medical transportation services as
604 determined by the division.

605 (9) Prescription drugs and other covered drugs and
606 services as determined by the division.

607 The division shall establish a mandatory preferred drug list.
608 Drugs not on the mandatory preferred drug list shall be made
609 available by utilizing prior authorization procedures established
610 by the division.



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

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

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

626 Drugs prescribed for a resident of a psychiatric residential
627 treatment facility must be provided in true unit doses when
628 available. The division may require that drugs not covered by
629 Medicare Part D for a resident of a long-term care facility be
630 provided in true unit doses when available. Those drugs that were
631 originally billed to the division but are not used by a resident
632 in any of those facilities shall be returned to the billing
633 pharmacy for credit to the division, in accordance with the
634 guidelines of the State Board of Pharmacy and any requirements of
635 federal law and regulation. Drugs shall be dispensed to a



636 recipient and only one (1) dispensing fee per month may be
637 charged. The division shall develop a methodology for reimbursing
638 for restocked drugs, which shall include a restock fee as
639 determined by the division not exceeding Seven Dollars and
640 Eighty-two Cents (\$7.82).

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

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

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

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

657 The division shall develop and implement a method or methods
658 by which the division will provide on a regular basis to Medicaid
659 providers who are authorized to prescribe drugs, information about
660 the costs to the Medicaid program of single-source drugs and



661 innovator multiple-source drugs, and information about other drugs
662 that may be prescribed as alternatives to those single-source
663 drugs and innovator multiple-source drugs and the costs to the
664 Medicaid program of those alternative drugs.

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

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

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

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

681 The division shall allow certain drugs, including
682 physician-administered drugs, and implantable drug system devices,
683 and medical supplies, with limited distribution or limited access
684 for beneficiaries and administered in an appropriate clinical



685 setting, to be reimbursed as either a medical claim or pharmacy
686 claim, as determined by the division.

687 * * * ~~It is the intent of the Legislature that the division and~~
688 ~~any managed care entity described in subsection (H) of this~~
689 ~~section encourage the use of Alpha-Hydroxyprogesterone Caproate~~
690 ~~(17P) to prevent recurrent preterm birth.~~

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

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

698 The division shall increase the amount of the reimbursement
699 rate for diagnostic and preventative dental services for each of
700 the fiscal years 2022, 2023 and 2024 by five percent (5%) above
701 the amount of the reimbursement rate for the previous fiscal year.
702 The division shall increase the amount of the reimbursement rate
703 for restorative dental services for each of the fiscal years 2023,
704 2024 and 2025 by five percent (5%) above the amount of the
705 reimbursement rate for the previous fiscal year. It is the intent
706 of the Legislature that the reimbursement rate revision for
707 preventative dental services will be an incentive to increase the
708 number of dentists who actively provide Medicaid services. This



709 dental services reimbursement rate revision shall be known as the
710 "James Russell Dumas Medicaid Dental Services Incentive Program."

711 The Medical Care Advisory Committee, assisted by the Division
712 of Medicaid, shall annually determine the effect of this incentive
713 by evaluating the number of dentists who are Medicaid providers,
714 the number who and the degree to which they are actively billing
715 Medicaid, the geographic trends of where dentists are offering
716 what types of Medicaid services and other statistics pertinent to
717 the goals of this legislative intent. This data shall annually be
718 presented to the Chair of the Senate Medicaid Committee and the
719 Chair of the House Medicaid Committee.

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

723 (11) Eyeglasses for all Medicaid beneficiaries who have
724 (a) had surgery on the eyeball or ocular muscle that results in a
725 vision change for which eyeglasses or a change in eyeglasses is
726 medically indicated within six (6) months of the surgery and is in
727 accordance with policies established by the division, or (b) one
728 (1) pair every * * * ~~five (5)~~ two (2) years and in accordance with
729 policies established by the division. In either instance, the
730 eyeglasses must be prescribed by a physician skilled in diseases
731 of the eye or an optometrist, whichever the beneficiary may
732 select.

733 (12) Intermediate care facility services.



734 (a) The division shall make full payment to all
735 intermediate care facilities for individuals with intellectual
736 disabilities for each day, not exceeding sixty-three (63) days per
737 year, that a patient is absent from the facility on home leave.
738 Payment may be made for the following home leave days in addition
739 to the sixty-three-day limitation: Christmas, the day before
740 Christmas, the day after Christmas, Thanksgiving, the day before
741 Thanksgiving and the day after Thanksgiving.

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

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

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

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



758 (a) Services provided by ambulatory surgical
759 centers (ACSS) as defined in Section 41-75-1(a); and
760 (b) Dialysis center services.

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

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

770 (16) Mental health services. Certain services provided
771 by a psychiatrist shall be reimbursed at up to one hundred percent
772 (100%) of the Medicare rate. Approved therapeutic and case
773 management services (a) provided by an approved regional mental
774 health/intellectual disability center established under Sections
775 41-19-31 through 41-19-39, or by another community mental health
776 service provider meeting the requirements of the Department of
777 Mental Health to be an approved mental health/intellectual
778 disability center if determined necessary by the Department of
779 Mental Health, using state funds that are provided in the
780 appropriation to the division to match federal funds, or (b)
781 provided by a facility that is certified by the State Department
782 of Mental Health to provide therapeutic and case management



783 services, to be reimbursed on a fee for service basis, or (c)
784 provided in the community by a facility or program operated by the
785 Department of Mental Health. Any such services provided by a
786 facility described in subparagraph (b) must have the prior
787 approval of the division to be reimbursable under this section.

788 (17) Durable medical equipment services and medical
789 supplies. Precertification of durable medical equipment and
790 medical supplies must be obtained as required by the division.
791 The Division of Medicaid may require durable medical equipment
792 providers to obtain a surety bond in the amount and to the
793 specifications as established by the Balanced Budget Act of 1997.
794 A maximum dollar amount of reimbursement for noninvasive
795 ventilators or ventilation treatments properly ordered and being
796 used in an appropriate care setting shall not be set by any health
797 maintenance organization, coordinated care organization,
798 provider-sponsored health plan, or other organization paid for
799 services on a capitated basis by the division under any managed
800 care program or coordinated care program implemented by the
801 division under this section. Reimbursement by these organizations
802 to durable medical equipment suppliers for home use of noninvasive
803 and invasive ventilators shall be on a continuous monthly payment
804 basis for the duration of medical need throughout a patient's
805 valid prescription period.



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

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

824 (b) (i) 1. The division may establish a Medicare
825 Upper Payment Limits Program, as defined in Section 1902(a)(30) of
826 the federal Social Security Act and any applicable federal
827 regulations, or an allowable delivery system or provider payment
828 initiative authorized under 42 CFR 438.6(c), for hospitals,
829 nursing facilities * * * ~~and,~~ physicians and other eligible
830 licensed providers as determined by the division employed or



831 contracted by hospitals. The division shall not limit
832 participation in this program to certain hospitals and shall
833 ensure it is available to all hospitals.

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

840 (ii) The division shall assess each hospital,
841 nursing facility, and emergency ambulance transportation provider
842 for the sole purpose of financing the state portion of the
843 Medicare Upper Payment Limits Program or other program(s)
844 authorized under this subsection (A)(18)(b). The hospital
845 assessment shall be as provided in Section 43-13-145(4)(a), and
846 the nursing facility and the emergency ambulance transportation
847 assessments, if established, shall be based on Medicaid
848 utilization or other appropriate method, as determined by the
849 division, consistent with federal regulations. The assessments
850 will remain in effect as long as the state participates in the
851 Medicare Upper Payment Limits Program or other program(s)
852 authorized under this subsection (A)(18)(b). In addition to the
853 hospital assessment provided in Section 43-13-145(4)(a), hospitals
854 with physicians and other eligible licensed providers as
855 determined by the division participating in the Medicare Upper



856 Payment Limits Program or other program(s) authorized under this
857 subsection (A) (18) (b) shall be required to participate in an
858 intergovernmental transfer or assessment, as determined by the
859 division, for the purpose of financing the state portion of the
860 physician UPL payments or other payment(s) authorized under this
861 subsection (A) (18) (b).

862 (iii) Subject to approval by the Centers for
863 Medicare and Medicaid Services (CMS) and the provisions of this
864 subsection (A) (18) (b), the division shall make additional
865 reimbursement to hospitals, nursing facilities, and emergency
866 ambulance transportation providers for the Medicare Upper Payment
867 Limits Program or other program(s) authorized under this
868 subsection (A) (18) (b), and, if the program is established for
869 physicians and other eligible licensed providers as determined by
870 the division, shall make additional reimbursement for physicians
871 and other eligible licensed providers as determined by the
872 division, as defined in Section 1902(a) (30) of the federal Social
873 Security Act and any applicable federal regulations, provided the
874 assessment in this subsection (A) (18) (b) is in effect.

875 (iv) * * * ~~Notwithstanding any other~~
876 ~~provision of this article to the contrary, effective upon~~
877 ~~implementation of the Mississippi Hospital Access Program (MHAP)~~
878 ~~provided in subparagraph (c) (i) below, the hospital portion of the~~
879 ~~inpatient Upper Payment Limits Program shall transition into and~~
880 ~~be replaced by the MHAP program. However, The division is~~



881 authorized to develop and implement an alternative fee-for-service
882 Upper Payment Limits model in accordance with federal laws and
883 regulations if necessary to preserve supplemental funding. * * *
884 ~~Further, the division, in consultation with the hospital industry~~
885 ~~shall develop alternative models for distribution of medical~~
886 ~~claims and supplemental payments for inpatient and outpatient~~
887 ~~hospital services, and such models may include, but shall not be~~
888 ~~limited to the following: increasing rates for inpatient and~~
889 ~~outpatient services; creating a low-income utilization pool of~~
890 ~~funds to reimburse hospitals for the costs of uncompensated care,~~
891 ~~charity care and bad debts as permitted and approved pursuant to~~
892 ~~federal regulations and the Centers for Medicare and Medicaid~~
893 ~~Services; supplemental payments based upon Medicaid utilization,~~
894 ~~quality, service lines and/or costs of providing such services to~~
895 ~~Medicaid beneficiaries and to uninsured patients. The goals of~~
896 ~~such payment models shall be to ensure access to inpatient and~~
897 ~~outpatient care and to maximize any federal funds that are~~
898 ~~available to reimburse hospitals for services provided. Any such~~
899 ~~documents required to achieve the goals described in this~~
900 ~~paragraph shall be submitted to the Centers for Medicare and~~
901 ~~Medicaid Services, with a proposed effective date of July 1, 2019,~~
902 ~~to the extent possible, but in no event shall the effective date~~
903 ~~of such payment models be later than July 1, 2020. The Chairmen~~
904 ~~of the Senate and House Medicaid Committees shall be provided a~~
905 ~~copy of the proposed payment model(s) prior to submission.~~



906 ~~Effective July 1, 2018, and until such time as any payment~~
907 ~~model(s) as described above become effective, the division, in~~
908 ~~consultation with the hospital industry, is authorized to~~
909 ~~implement a transitional program for inpatient and outpatient~~
910 ~~payments and/or supplemental payments (including, but not limited~~
911 ~~to, MHAP and directed payments), to redistribute available~~
912 ~~supplemental funds among hospital providers, provided that when~~
913 ~~compared to a hospital's prior year supplemental payments,~~
914 ~~supplemental payments made pursuant to any such transitional~~
915 ~~program shall not result in a decrease of more than five percent~~
916 ~~(5%) and shall not increase by more than the amount needed to~~
917 ~~maximize the distribution of the available funds. The division,~~
918 ~~in consultation with the Mississippi Hospital Association, may~~
919 ~~develop alternative models for distribution of medical claims and~~
920 ~~supplemental payments for inpatient and outpatient hospital~~
921 ~~services, and such models may include, but shall not be limited~~
922 ~~to, the following: increasing rates for inpatient and outpatient~~
923 ~~services; creating a low-income utilization pool of funds to~~
924 ~~reimburse hospitals for the costs of uncompensated care, charity~~
925 ~~care and bad debts as permitted and approved pursuant to federal~~
926 ~~regulations and the Centers for Medicare and Medicaid Services;~~
927 ~~supplemental payments based upon Medicaid utilization, quality,~~
928 ~~service lines and/or costs of providing such services to Medicaid~~
929 ~~beneficiaries and to uninsured patients. The goals of such~~
930 ~~payment models shall be to ensure access to inpatient and~~



931 outpatient care and to maximize any federal funds that are
932 available to reimburse hospitals for services provided. The
933 Chairmen of the Senate and House Medicaid Committees shall be
934 provided copies of the proposed payment model(s) prior to
935 submission.

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

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

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



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

964 c. As used in this paragraph
965 (18) (b) (v), the term "upper payment limit gap" means the
966 difference between the total amount that the ambulance
967 transportation service provider received from Medicaid and the
968 average amount that the ambulance transportation service provider
969 would have received from commercial insurers for those services
970 reimbursed by Medicaid.

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

974 (c) (i) * * * ~~Not later than December 1, 2015,~~
975 The division shall, subject to approval by the Centers for
976 Medicare and Medicaid Services (CMS), establish, implement and
977 operate a Mississippi Hospital Access Program (MHAP) for the
978 purpose of protecting patient access to hospital care through
979 hospital inpatient reimbursement programs provided in this section



980 designed to maintain total hospital reimbursement for inpatient
981 services rendered by in-state hospitals and the out-of-state
982 hospital that is authorized by federal law to submit
983 intergovernmental transfers (IGTs) to the State of Mississippi and
984 is classified as Level I trauma center located in a county
985 contiguous to the state line at the maximum levels permissible
986 under applicable federal statutes and regulations * * *, ~~at which~~
987 ~~time the current inpatient Medicare Upper Payment Limits (UPL)~~
988 ~~Program for hospital inpatient services shall transition to the~~
989 ~~MHAP.~~

990 (ii) Subject to approval by the Centers for
991 Medicare and Medicaid Services (CMS), the MHAP shall provide
992 increased inpatient capitation (PMPM) payments to managed care
993 entities contracting with the division pursuant to subsection (H)
994 of this section to support availability of hospital services or
995 such other payments permissible under federal law necessary to
996 accomplish the intent of this subsection.

997 (iii) The intent of this subparagraph (c) is
998 that effective for all inpatient hospital Medicaid services during
999 state fiscal year 2016, and so long as this provision shall remain
1000 in effect hereafter, the division * * * ~~shall~~ may, to the fullest
1001 extent feasible, l replace the additional reimbursement for hospital
1002 inpatient services under the inpatient Medicare Upper Payment
1003 Limits (UPL) Program with additional reimbursement under the MHAP
1004 and other payment programs for inpatient and/or outpatient



1005 payments which may be developed under the authority of this
1006 paragraph.

1007 (iv) The division shall assess each hospital
1008 as provided in Section 43-13-145(4) (a) for the purpose of
1009 financing the state portion of the MHAP, supplemental payments and
1010 such other purposes as specified in Section 43-13-145. The
1011 assessment will remain in effect as long as the MHAP and
1012 supplemental payments are in effect.

1013 (d) Supplemental payments to a hospital shall not
1014 decrease by more than five percent (5%) when compared to a
1015 hospital's prior year payment unless that hospital has closed, or
1016 changed services or patient volume which impact that hospital's
1017 payment, and the division shall not substantially change the
1018 methodologies used to calculate a hospital's supplemental payment.
1019 Nothing in this paragraph shall be construed to prohibit an
1020 increase in total funding available for hospital supplemental
1021 payment programs. For Mississippi providers described under this
1022 section, the division shall, subject to approval by the Centers
1023 for Medicare and Medicaid Services (CMS), implement and operate
1024 supplemental payment programs at the maximum levels permissible
1025 under applicable federal statutes and regulations.

1026 (19) (a) Perinatal risk-management 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 shall contract with the
1044 State Department of Health for these services, and the programs
1045 shall begin providing these services no later than January 1,
1046 2026.

1047 (b) Early intervention system services. The
1048 division shall cooperate with the State Department of Health,
1049 acting as lead agency, in the development and implementation of a
1050 statewide system of delivery of early intervention services, under
1051 Part C of the Individuals with Disabilities Education Act (IDEA).
1052 The State Department of Health shall certify annually in writing
1053 to the executive director of the division the dollar amount of
1054 state early intervention funds available that will be utilized as



1055 a certified match for Medicaid matching funds. Those funds then
1056 shall be used to provide expanded targeted case management
1057 services for Medicaid eligible children with special needs who are
1058 eligible for the state's early intervention system.

1059 Qualifications for persons providing service coordination shall be
1060 determined by the State Department of Health and the Division of
1061 Medicaid.

1062 (20) Home- and community-based services for physically
1063 disabled approved services as allowed by a waiver from the United
1064 States Department of Health and Human Services for home- and
1065 community-based services for physically disabled people using
1066 state funds that are provided from the appropriation to the State
1067 Department of Rehabilitation Services and used to match federal
1068 funds under a cooperative agreement between the division and the
1069 department, provided that funds for these services are
1070 specifically appropriated to the Department of Rehabilitation
1071 Services.

1072 (21) Nurse practitioner services. Services furnished
1073 by a registered nurse who is licensed and certified by the
1074 Mississippi Board of Nursing as a nurse practitioner, including,
1075 but not limited to, nurse anesthetists, nurse midwives, family
1076 nurse practitioners, family planning nurse practitioners,
1077 pediatric nurse practitioners, obstetrics-gynecology nurse
1078 practitioners and neonatal nurse practitioners, under regulations
1079 adopted by the division. Reimbursement for those services shall



1080 not exceed ninety percent (90%) of the reimbursement rate for
1081 comparable services rendered by a physician. The division may
1082 provide for a reimbursement rate for nurse practitioner services
1083 of up to one hundred percent (100%) of the reimbursement rate for
1084 comparable services rendered by a physician for nurse practitioner
1085 services that are provided after the normal working hours of the
1086 nurse practitioner, as determined in accordance with regulations
1087 of the division.

1088 (22) Ambulatory services delivered in federally
1089 qualified health centers, rural health centers and clinics of the
1090 local health departments of the State Department of Health for
1091 individuals eligible for Medicaid under this article based on
1092 reasonable costs as determined by the division. Federally
1093 qualified health centers shall be reimbursed by the Medicaid
1094 prospective payment system as approved by the Centers for Medicare
1095 and Medicaid Services. The division shall recognize federally
1096 qualified health centers (FQHCs), rural health clinics (RHCs) and
1097 community mental health centers (CMHCs) as both an originating and
1098 distant site provider for the purposes of telehealth
1099 reimbursement. The division is further authorized and directed to
1100 reimburse FQHCs, RHCs and CMHCs for both distant site and
1101 originating site services when such services are appropriately
1102 provided by the same organization.

1103 (23) Inpatient psychiatric services.



1104 (a) Inpatient psychiatric services to be
1105 determined by the division for recipients under age twenty-one
1106 (21) that are provided under the direction of a physician in an
1107 inpatient program in a licensed acute care psychiatric facility or
1108 in a licensed psychiatric residential treatment facility, before
1109 the recipient reaches age twenty-one (21) or, if the recipient was
1110 receiving the services immediately before he or she reached age
1111 twenty-one (21), before the earlier of the date he or she no
1112 longer requires the services or the date he or she reaches age
1113 twenty-two (22), as provided by federal regulations. From and
1114 after January 1, 2015, the division shall update the fair rental
1115 reimbursement system for psychiatric residential treatment
1116 facilities. Precertification of inpatient days and residential
1117 treatment days must be obtained as required by the division. From
1118 and after July 1, 2009, all state-owned and state-operated
1119 facilities that provide inpatient psychiatric services to persons
1120 under age twenty-one (21) who are eligible for Medicaid
1121 reimbursement shall be reimbursed for those services on a full
1122 reasonable cost basis.

1123 (b) The division may reimburse for services
1124 provided by a licensed freestanding psychiatric hospital to
1125 Medicaid recipients over the age of twenty-one (21) in a method
1126 and manner consistent with the provisions of Section 43-13-117.5.



1127 (24) * * *—[Deleted] Certified Community Behavioral
1128 Health Centers (CCBHCs). The division may reimburse CCBHCs in a
1129 manner as determined by the division.

1130 (25) [Deleted]

1131 (26) Hospice care. As used in this paragraph, the term
1132 "hospice care" means a coordinated program of active professional
1133 medical attention within the home and outpatient and inpatient
1134 care that treats the terminally ill patient and family as a unit,
1135 employing a medically directed interdisciplinary team. The
1136 program provides relief of severe pain or other physical symptoms
1137 and supportive care to meet the special needs arising out of
1138 physical, psychological, spiritual, social and economic stresses
1139 that are experienced during the final stages of illness and during
1140 dying and bereavement and meets the Medicare requirements for
1141 participation as a hospice as provided in federal regulations.

1142 (27) Group health plan premiums and cost-sharing if it
1143 is cost-effective as defined by the United States Secretary of
1144 Health and Human Services.

1145 (28) Other health insurance premiums that are
1146 cost-effective as defined by the United States Secretary of Health
1147 and Human Services. Medicare eligible must have Medicare Part B
1148 before other insurance premiums can be paid.

1149 (29) The Division of Medicaid may apply for a waiver
1150 from the United States Department of Health and Human Services for
1151 home- and community-based services for developmentally disabled



1152 people using state funds that are provided from the appropriation
1153 to the State Department of Mental Health and/or funds transferred
1154 to the department by a political subdivision or instrumentality of
1155 the state and used to match federal funds under a cooperative
1156 agreement between the division and the department, provided that
1157 funds for these services are specifically appropriated to the
1158 Department of Mental Health and/or transferred to the department
1159 by a political subdivision or instrumentality of the state.

1160 (30) Pediatric skilled nursing services as determined
1161 by the division and in a manner consistent with regulations
1162 promulgated by the Mississippi State Department of Health.

1163 (31) Targeted case management services for children
1164 with special needs, under waivers from the United States
1165 Department of Health and Human Services, using state funds that
1166 are provided from the appropriation to the Mississippi Department
1167 of Human Services and used to match federal funds under a
1168 cooperative agreement between the division and the department.

1169 (32) Care and services provided in Christian Science
1170 Sanatoria listed and certified by the Commission for Accreditation
1171 of Christian Science Nursing Organizations/Facilities, Inc.,
1172 rendered in connection with treatment by prayer or spiritual means
1173 to the extent that those services are subject to reimbursement
1174 under Section 1903 of the federal Social Security Act.

1175 (33) Podiatrist services.



1176 (34) Assisted living services as provided through
1177 home- and community-based services under Title XIX of the federal
1178 Social Security Act, as amended, subject to the availability of
1179 funds specifically appropriated for that purpose by the
1180 Legislature.

1181 (35) Services and activities authorized in Sections
1182 43-27-101 and 43-27-103, using state funds that are provided from
1183 the appropriation to the Mississippi Department of Human Services
1184 and used to match federal funds under a cooperative agreement
1185 between the division and the department.

1186 (36) Nonemergency transportation services for
1187 Medicaid-eligible persons as determined by the division. The PEER
1188 Committee shall conduct a performance evaluation of the
1189 nonemergency transportation program to evaluate the administration
1190 of the program and the providers of transportation services to
1191 determine the most cost-effective ways of providing nonemergency
1192 transportation services to the patients served under the program.
1193 The performance evaluation shall be completed and provided to the
1194 members of the Senate Medicaid Committee and the House Medicaid
1195 Committee not later than January 1, 2019, and every two (2) years
1196 thereafter.

1197 (37) [Deleted]

1198 (38) Chiropractic services. A chiropractor's manual
1199 manipulation of the spine to correct a subluxation, if x-ray
1200 demonstrates that a subluxation exists and if the subluxation has



1201 resulted in a neuromusculoskeletal condition for which
1202 manipulation is appropriate treatment, and related spinal x-rays
1203 performed to document these conditions. Reimbursement for
1204 chiropractic services shall not exceed Seven Hundred Dollars
1205 (\$700.00) per year per beneficiary.

1206 (39) Dually eligible Medicare/Medicaid beneficiaries.
1207 The division shall pay the Medicare deductible and coinsurance
1208 amounts for services available under Medicare, as determined by
1209 the division. From and after July 1, 2009, the division shall
1210 reimburse crossover claims for inpatient hospital services and
1211 crossover claims covered under Medicare Part B in the same manner
1212 that was in effect on January 1, 2008, unless specifically
1213 authorized by the Legislature to change this method.

1214 (40) [Deleted]

1215 (41) Services provided by the State Department of
1216 Rehabilitation Services for the care and rehabilitation of persons
1217 with spinal cord injuries or traumatic brain injuries, as allowed
1218 under waivers from the United States Department of Health and
1219 Human Services, using up to seventy-five percent (75%) of the
1220 funds that are appropriated to the Department of Rehabilitation
1221 Services from the Spinal Cord and Head Injury Trust Fund
1222 established under Section 37-33-261 and used to match federal
1223 funds under a cooperative agreement between the division and the
1224 department.

1225 (42) [Deleted]



1226 (43) The division shall provide reimbursement,
1227 according to a payment schedule developed by the division, for
1228 smoking cessation medications for pregnant women during their
1229 pregnancy and other Medicaid-eligible women who are of
1230 child-bearing age.

1231 (44) Nursing facility services for the severely
1232 disabled.

1233 (a) Severe disabilities include, but are not
1234 limited to, spinal cord injuries, closed-head injuries and
1235 ventilator-dependent patients.

1236 (b) Those services must be provided in a long-term
1237 care nursing facility dedicated to the care and treatment of
1238 persons with severe disabilities.

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



1250 hours of the physician assistant, as determined in accordance with
1251 regulations of the division.

1252 (46) The division shall make application to the federal
1253 Centers for Medicare and Medicaid Services (CMS) for a waiver to
1254 develop and provide services for children with serious emotional
1255 disturbances as defined in Section 43-14-1(1), which may include
1256 home- and community-based services, case management services or
1257 managed care services through mental health providers certified by
1258 the Department of Mental Health. The division may implement and
1259 provide services under this waived program only if funds for
1260 these services are specifically appropriated for this purpose by
1261 the Legislature, or if funds are voluntarily provided by affected
1262 agencies.

1263 (47) (a) The division may develop and implement
1264 disease management programs for individuals with high-cost chronic
1265 diseases and conditions, including the use of grants, waivers,
1266 demonstrations or other projects as necessary.

1267 (b) Participation in any disease management
1268 program implemented under this paragraph (47) is optional with the
1269 individual. An individual must affirmatively elect to participate
1270 in the disease management program in order to participate, and may
1271 elect to discontinue participation in the program at any time.

1272 (48) Pediatric long-term acute care hospital services.

1273 (a) Pediatric long-term acute care hospital
1274 services means services provided to eligible persons under



1275 twenty-one (21) years of age by a freestanding Medicare-certified
1276 hospital that has an average length of inpatient stay greater than
1277 twenty-five (25) days and that is primarily engaged in providing
1278 chronic or long-term medical care to persons under twenty-one (21)
1279 years of age.

1280 (b) The services under this paragraph (48) shall
1281 be reimbursed as a separate category of hospital services.

1282 (49) The division may establish copayments and/or
1283 coinsurance for any Medicaid services for which copayments and/or
1284 coinsurance are allowable under federal law or regulation.

1285 (50) Services provided by the State Department of
1286 Rehabilitation Services for the care and rehabilitation of persons
1287 who are deaf and blind, as allowed under waivers from the United
1288 States Department of Health and Human Services to provide home-
1289 and community-based services using state funds that are provided
1290 from the appropriation to the State Department of Rehabilitation
1291 Services or if funds are voluntarily provided by another agency.

1292 (51) Upon determination of Medicaid eligibility and in
1293 association with annual redetermination of Medicaid eligibility,
1294 beneficiaries shall be encouraged to undertake a physical
1295 examination that will establish a base-line level of health and
1296 identification of a usual and customary source of care (a medical
1297 home) to aid utilization of disease management tools. This
1298 physical examination and utilization of these disease management



1299 tools shall be consistent with current United States Preventive
1300 Services Task Force or other recognized authority recommendations.

1301 For persons who are determined ineligible for Medicaid, the
1302 division will provide information and direction for accessing
1303 medical care and services in the area of their residence.

1304 (52) Notwithstanding any provisions of this article,
1305 the division may pay enhanced reimbursement fees related to trauma
1306 care, as determined by the division in conjunction with the State
1307 Department of Health, using funds appropriated to the State
1308 Department of Health for trauma care and services and used to
1309 match federal funds under a cooperative agreement between the
1310 division and the State Department of Health. The division, in
1311 conjunction with the State Department of Health, may use grants,
1312 waivers, demonstrations, enhanced reimbursements, Upper Payment
1313 Limits Programs, supplemental payments, or other projects as
1314 necessary in the development and implementation of this
1315 reimbursement program.

1316 (53) Targeted case management services for high-cost
1317 beneficiaries may be developed by the division for all services
1318 under this section.

1319 (54) [Deleted]

1320 (55) Therapy services. The plan of care for therapy
1321 services may be developed to cover a period of treatment for up to
1322 six (6) months, but in no event shall the plan of care exceed a
1323 six-month period of treatment. The projected period of treatment



1324 must be indicated on the initial plan of care and must be updated
1325 with each subsequent revised plan of care. Based on medical
1326 necessity, the division shall approve certification periods for
1327 less than or up to six (6) months, but in no event shall the
1328 certification period exceed the period of treatment indicated on
1329 the plan of care. The appeal process for any reduction in therapy
1330 services shall be consistent with the appeal process in federal
1331 regulations.

1332 (56) Prescribed pediatric extended care centers
1333 services for medically dependent or technologically dependent
1334 children with complex medical conditions that require continual
1335 care as prescribed by the child's attending physician, as
1336 determined by the division.

1337 (57) No Medicaid benefit shall restrict coverage for
1338 medically appropriate treatment prescribed by a physician and
1339 agreed to by a fully informed individual, or if the individual
1340 lacks legal capacity to consent by a person who has legal
1341 authority to consent on his or her behalf, based on an
1342 individual's diagnosis with a terminal condition. As used in this
1343 paragraph (57), "terminal condition" means any aggressive
1344 malignancy, chronic end-stage cardiovascular or cerebral vascular
1345 disease, or any other disease, illness or condition which a
1346 physician diagnoses as terminal.

1347 (58) Treatment services for persons with opioid
1348 dependency or other highly addictive substance use disorders. The



1349 division is authorized to reimburse eligible providers for
1350 treatment of opioid dependency and other highly addictive
1351 substance use disorders, as determined by the division. Treatment
1352 related to these conditions shall not count against any physician
1353 visit limit imposed under this section.

1354 (59) The division shall allow beneficiaries between the
1355 ages of ten (10) and eighteen (18) years to receive vaccines
1356 through a pharmacy venue. The division and the State Department
1357 of Health shall coordinate and notify OB-GYN providers that the
1358 Vaccines for Children program is available to providers free of
1359 charge.

1360 (60) Border city university-affiliated pediatric
1361 teaching hospital.

1362 (a) Payments may only be made to a border city
1363 university-affiliated pediatric teaching hospital if the Centers
1364 for Medicare and Medicaid Services (CMS) approve an increase in
1365 the annual request for the provider payment initiative authorized
1366 under 42 CFR Section 438.6(c) in an amount equal to or greater
1367 than the estimated annual payment to be made to the border city
1368 university-affiliated pediatric teaching hospital. The estimate
1369 shall be based on the hospital's prior year Mississippi managed
1370 care utilization.

1371 (b) As used in this paragraph (60), the term
1372 "border city university-affiliated pediatric teaching hospital"
1373 means an out-of-state hospital located within a city bordering the



1374 eastern bank of the Mississippi River and the State of Mississippi
1375 that submits to the division a copy of a current and effective
1376 affiliation agreement with an accredited university and other
1377 documentation establishing that the hospital is
1378 university-affiliated, is licensed and designated as a pediatric
1379 hospital or pediatric primary hospital within its home state,
1380 maintains at least five (5) different pediatric specialty training
1381 programs, and maintains at least one hundred (100) operated beds
1382 dedicated exclusively for the treatment of patients under the age
1383 of twenty-one (21) years.

1384 (c) The cost of providing services to Mississippi
1385 Medicaid beneficiaries under the age of twenty-one (21) years who
1386 are treated by a border city university-affiliated pediatric
1387 teaching hospital shall not exceed the cost of providing the same
1388 services to individuals in hospitals in the state.

1389 (d) It is the intent of the Legislature that
1390 payments shall not result in any in-state hospital receiving
1391 payments lower than they would otherwise receive if not for the
1392 payments made to any border city university-affiliated pediatric
1393 teaching hospital.

1394 (e) This paragraph (60) shall stand repealed on
1395 July 1, * * * ~~2028~~ 2029.

1396 (61) Autism spectrum disorder services. The division
1397 shall develop and implement a method for reimbursement of autism
1398 spectrum disorder services based on a continuum of care for best



1399 practices in medically necessary early intervention treatment.
1400 The division shall work in consultation with the Department of
1401 Mental Health, healthcare providers, the Autism Advisory
1402 Committee, and other stakeholders relevant to the autism industry
1403 to develop these reimbursement rates. The requirements of this
1404 subsection shall apply to any autism spectrum disorder services
1405 rendered under the authority of the Medicaid State Plan and any
1406 Home and Community Based Services Waiver authorized under this
1407 section through which autism spectrum disorder services are
1408 provided.

1409 (62) Preparticipation physical evaluations. The
1410 division shall reimburse for preparticipation physical evaluations
1411 of beneficiaries in a manner as determined by the division.

1412 (63) Glucagon-like peptide-1 (GLP-1) agonist
1413 medications that have been approved for chronic weight management
1414 by the United States Food and Drug Administration (FDA). The
1415 division shall, in a manner as determined by the division,
1416 reimburse for FDA-approved GLP-1 agonist medications prescribed
1417 for chronic weight management and/or for management of additional
1418 conditions in the discretion of the medical provider.

1419 (64) Coverage and reimbursement for postpartum
1420 depression screening. The division and any managed care entity
1421 described in subsection (H) of this section shall provide coverage
1422 for postpartum depression screening required pursuant to Section
1423 41-140-5. Such coverage shall provide for additional



1424 reimbursement for the administration of postpartum depression
1425 screening adequate to compensate the health care provider for the
1426 provision of such screening and consistent with ensuring broad
1427 access to postpartum depression screening in line with
1428 evidence-based guidelines.

1429 (B) Planning and development districts participating in the
1430 home- and community-based services program for the elderly and
1431 disabled as case management providers shall be reimbursed for case
1432 management services at the maximum rate approved by the Centers
1433 for Medicare and Medicaid Services (CMS).

1434 (C) The division may pay to those providers who participate
1435 in and accept patient referrals from the division's emergency room
1436 redirection program a percentage, as determined by the division,
1437 of savings achieved according to the performance measures and
1438 reduction of costs required of that program. Federally qualified
1439 health centers may participate in the emergency room redirection
1440 program, and the division may pay those centers a percentage of
1441 any savings to the Medicaid program achieved by the centers'
1442 accepting patient referrals through the program, as provided in
1443 this subsection (C).

1444 (D) (1) As used in this subsection (D), the following terms
1445 shall be defined as provided in this paragraph, except as
1446 otherwise provided in this subsection:



1447 (a) "Committees" means the Medicaid Committees of
1448 the House of Representatives and the Senate, and "committee" means
1449 either one of those committees.

1450 (b) "Rate change" means an increase, decrease or
1451 other change in the payments or rates of reimbursement, or a
1452 change in any payment methodology that results in an increase,
1453 decrease or other change in the payments or rates of
1454 reimbursement, to any Medicaid provider that renders any services
1455 authorized to be provided to Medicaid recipients under this
1456 article.

1457 (2) Whenever the Division of Medicaid proposes a rate
1458 change, the division shall give notice to the chairmen of the
1459 committees at least * * * ~~thirty (30)~~ fifteen (15) calendar days
1460 before the proposed rate change is scheduled to take effect. The
1461 division shall furnish the chairmen with a concise summary of each
1462 proposed rate change along with the notice, and shall furnish the
1463 chairmen with a copy of any proposed rate change upon request.
1464 The division also shall provide a summary and copy of any proposed
1465 rate change to any other member of the Legislature upon request.

1466 (3) If the chairman of either committee or both
1467 chairmen jointly object to the proposed rate change or any part
1468 thereof, the chairman or chairmen shall notify the division and
1469 provide the reasons for their objection in writing not later than
1470 seven (7) calendar days after receipt of the notice from the
1471 division. The chairman or chairmen may make written



1472 recommendations to the division for changes to be made to a
1473 proposed rate change.

1474 (4) (a) The chairman of either committee or both
1475 chairmen jointly may hold a committee meeting to review a proposed
1476 rate change. If either chairman or both chairmen decide to hold a
1477 meeting, they shall notify the division of their intention in
1478 writing within seven (7) calendar days after receipt of the notice
1479 from the division, and shall set the date and time for the meeting
1480 in their notice to the division, which shall not be later than
1481 fourteen (14) calendar days after receipt of the notice from the
1482 division.

1483 (b) After the committee meeting, the committee or
1484 committees may object to the proposed rate change or any part
1485 thereof. The committee or committees shall notify the division
1486 and the reasons for their objection in writing not later than
1487 seven (7) calendar days after the meeting. The committee or
1488 committees may make written recommendations to the division for
1489 changes to be made to a proposed rate change.

1490 (5) If both chairmen notify the division in writing
1491 within seven (7) calendar days after receipt of the notice from
1492 the division that they do not object to the proposed rate change
1493 and will not be holding a meeting to review the proposed rate
1494 change, the proposed rate change will take effect on the original
1495 date as scheduled by the division or on such other date as
1496 specified by the division.



1497 (6) (a) If there are any objections to a proposed rate
1498 change or any part thereof from either or both of the chairmen or
1499 the committees, the division may withdraw the proposed rate
1500 change, make any of the recommended changes to the proposed rate
1501 change, or not make any changes to the proposed rate change.

1502 (b) If the division does not make any changes to
1503 the proposed rate change, it shall notify the chairmen of that
1504 fact in writing, and the proposed rate change shall take effect on
1505 the original date as scheduled by the division or on such other
1506 date as specified by the division.

1507 (c) If the division makes any changes to the
1508 proposed rate change, the division shall notify the chairmen of
1509 its actions in writing, and the revised proposed rate change shall
1510 take effect on the date as specified by the division.

1511 (7) Nothing in this subsection (D) shall be construed
1512 as giving the chairmen or the committees any authority to veto,
1513 nullify or revise any rate change proposed by the division. The
1514 authority of the chairmen or the committees under this subsection
1515 shall be limited to reviewing, making objections to and making
1516 recommendations for changes to rate changes proposed by the
1517 division.

1518 (8) If the division needs to expedite the fifteen-day
1519 legislative notice set forth in paragraph (2) of this subsection
1520 (D), the division shall notify both chairmen.



1521 (E) Notwithstanding any provision of this article, no new
1522 groups or categories of recipients and new types of care and
1523 services may be added without enabling legislation from the
1524 Mississippi Legislature, except that the division may authorize
1525 those changes without enabling legislation when the addition of
1526 recipients or services is ordered by a court of proper authority.

1527 (F) The executive director shall keep the Governor advised
1528 on a timely basis of the funds available for expenditure and the
1529 projected expenditures. Notwithstanding any other provisions of
1530 this article, if current or projected expenditures of the division
1531 are reasonably anticipated to exceed the amount of funds
1532 appropriated to the division for any fiscal year, the Governor,
1533 after consultation with the executive director, shall take all
1534 appropriate measures to reduce costs, which may include, but are
1535 not limited to:

1536 (1) Reducing or discontinuing any or all services that
1537 are deemed to be optional under Title XIX of the Social Security
1538 Act;

1539 (2) Reducing reimbursement rates for any or all service
1540 types;

1541 (3) Imposing additional assessments on health care
1542 providers; or

1543 (4) Any additional cost-containment measures deemed
1544 appropriate by the Governor.



1545 To the extent allowed under federal law, any reduction to
1546 services or reimbursement rates under this subsection (F) shall be
1547 accompanied by a reduction, to the fullest allowable amount, to
1548 the profit margin and administrative fee portions of capitated
1549 payments to organizations described in paragraph (1) of subsection
1550 (H).

1551 Beginning in fiscal year 2010 and in fiscal years thereafter,
1552 when Medicaid expenditures are projected to exceed funds available
1553 for the fiscal year, the division shall submit the expected
1554 shortfall information to the PEER Committee not later than
1555 December 1 of the year in which the shortfall is projected to
1556 occur. PEER shall review the computations of the division and
1557 report its findings to the Legislative Budget Office not later
1558 than January 7 in any year.

1559 (G) Notwithstanding any other provision of this article, it
1560 shall be the duty of each provider participating in the Medicaid
1561 program to keep and maintain books, documents and other records as
1562 prescribed by the Division of Medicaid in accordance with federal
1563 laws and regulations.

1564 (H) (1) Notwithstanding any other provision of this
1565 article, the division is authorized to implement (a) a managed
1566 care program, (b) a coordinated care program, (c) a coordinated
1567 care organization program, (d) a health maintenance organization
1568 program, (e) a patient-centered medical home program, (f) an
1569 accountable care organization program, (g) provider-sponsored



1570 health plan, or (h) any combination of the above programs. As a
1571 condition for the approval of any program under this subsection
1572 (H)(1), the division shall require that no managed care program,
1573 coordinated care program, coordinated care organization program,
1574 health maintenance organization program, or provider-sponsored
1575 health plan may:

1576 (a) Pay providers at a rate that is less than the
1577 Medicaid All Patient Refined Diagnosis Related Groups (APR-DRG)
1578 reimbursement rate;

1579 (b) Override the medical decisions of hospital
1580 physicians or staff regarding patients admitted to a hospital for
1581 an emergency medical condition as defined by 42 US Code Section
1582 1395dd. This restriction (b) does not prohibit the retrospective
1583 review of the appropriateness of the determination that an
1584 emergency medical condition exists by chart review or coding
1585 algorithm, nor does it prohibit prior authorization for
1586 nonemergency hospital admissions;

1587 (c) Pay providers at a rate that is less than the
1588 normal Medicaid reimbursement rate. It is the intent of the
1589 Legislature that all managed care entities described in this
1590 subsection (H), in collaboration with the division, develop and
1591 implement innovative payment models that incentivize improvements
1592 in health care quality, outcomes, or value, as determined by the
1593 division. Participation in the provider network of any managed
1594 care, coordinated care, provider-sponsored health plan, or similar



1595 contractor shall not be conditioned on the provider's agreement to
1596 accept such alternative payment models;

1597 (d) Implement a prior authorization and
1598 utilization review program for medical services, transportation
1599 services and prescription drugs that is more stringent than the
1600 prior authorization processes used by the division in its
1601 administration of the Medicaid program. Not later than December
1602 2, 2021, the contractors that are receiving capitated payments
1603 under a managed care delivery system established under this
1604 subsection (H) shall submit a report to the Chairmen of the House
1605 and Senate Medicaid Committees on the status of the prior
1606 authorization and utilization review program for medical services,
1607 transportation services and prescription drugs that is required to
1608 be implemented under this subparagraph (d);

1609 (e) [Deleted]

1610 (f) Implement a preferred drug list that is more
1611 stringent than the mandatory preferred drug list established by
1612 the division under subsection (A) (9) of this section;

1613 (g) Implement a policy which denies beneficiaries
1614 with hemophilia access to the federally funded hemophilia
1615 treatment centers as part of the Medicaid Managed Care network of
1616 providers.

1617 Each health maintenance organization, coordinated care
1618 organization, provider-sponsored health plan, or other
1619 organization paid for services on a capitated basis by the



1620 division under any managed care program or coordinated care
1621 program implemented by the division under this section shall use a
1622 clear set of level of care guidelines in the determination of
1623 medical necessity and in all utilization management practices,
1624 including the prior authorization process, concurrent reviews,
1625 retrospective reviews and payments, that are consistent with
1626 widely accepted professional standards of care. Organizations
1627 participating in a managed care program or coordinated care
1628 program implemented by the division may not use any additional
1629 criteria that would result in denial of care that would be
1630 determined appropriate and, therefore, medically necessary under
1631 those levels of care guidelines.

1632 (2) Notwithstanding any provision of this section, the
1633 recipients eligible for enrollment into a Medicaid Managed Care
1634 Program authorized under this subsection (H) may include only
1635 those categories of recipients eligible for participation in the
1636 Medicaid Managed Care Program as of January 1, 2021, the
1637 Children's Health Insurance Program (CHIP), and the CMS-approved
1638 Section 1115 demonstration waivers in operation as of January 1,
1639 2021. No expansion of Medicaid Managed Care Program contracts may
1640 be implemented by the division without enabling legislation from
1641 the Mississippi Legislature.

1642 (3) (a) Any contractors receiving capitated payments
1643 under a managed care delivery system established in this section
1644 shall provide to the Legislature and the division statistical data



1645 to be shared with provider groups in order to improve patient
1646 access, appropriate utilization, cost savings and health outcomes
1647 not later than October 1 of each year. Additionally, each
1648 contractor shall disclose to the Chairmen of the Senate and House
1649 Medicaid Committees the administrative expenses costs for the
1650 prior calendar year, and the number of full-equivalent employees
1651 located in the State of Mississippi dedicated to the Medicaid and
1652 CHIP lines of business as of June 30 of the current year.

1653 (b) The division and the contractors participating
1654 in the managed care program, a coordinated care program or a
1655 provider-sponsored health plan shall be subject to annual program
1656 reviews or audits performed by the Office of the State Auditor,
1657 the PEER Committee, the Department of Insurance and/or independent
1658 third parties.

1659 (c) Those reviews shall include, but not be
1660 limited to, at least two (2) of the following items:

1661 (i) The financial benefit to the State of
1662 Mississippi of the managed care program,

1663 (ii) The difference between the premiums paid
1664 to the managed care contractors and the payments made by those
1665 contractors to health care providers,

1666 (iii) Compliance with performance measures
1667 required under the contracts,

1668 (iv) Administrative expense allocation
1669 methodologies,



- 1670 (v) Whether nonprovider payments assigned as
1671 medical expenses are appropriate,
1672 (vi) Capitated arrangements with related
1673 party subcontractors,
1674 (vii) Reasonableness of corporate
1675 allocations,
1676 (viii) Value-added benefits and the extent to
1677 which they are used,
1678 (ix) The effectiveness of subcontractor
1679 oversight, including subcontractor review,
1680 (x) Whether health care outcomes have been
1681 improved, and
1682 (xi) The most common claim denial codes to
1683 determine the reasons for the denials.

1684 The audit reports shall be considered public documents and
1685 shall be posted in their entirety on the division's website.

1686 (4) All health maintenance organizations, coordinated
1687 care organizations, provider-sponsored health plans, or other
1688 organizations paid for services on a capitated basis by the
1689 division under any managed care program or coordinated care
1690 program implemented by the division under this section shall
1691 reimburse all providers in those organizations at rates no lower
1692 than those provided under this section for beneficiaries who are
1693 not participating in those programs.



1694 (5) No health maintenance organization, coordinated
1695 care organization, provider-sponsored health plan, or other
1696 organization paid for services on a capitated basis by the
1697 division under any managed care program or coordinated care
1698 program implemented by the division under this section shall
1699 require its providers or beneficiaries to use any pharmacy that
1700 ships, mails or delivers prescription drugs or legend drugs or
1701 devices.

1702 (6) (a) Not later than December 1, 2021, the
1703 contractors who are receiving capitated payments under a managed
1704 care delivery system established under this subsection (H) shall
1705 develop and implement a uniform credentialing process for
1706 providers. Under that uniform credentialing process, a provider
1707 who meets the criteria for credentialing will be credentialed with
1708 all of those contractors and no such provider will have to be
1709 separately credentialed by any individual contractor in order to
1710 receive reimbursement from the contractor. Not later than
1711 December 2, 2021, those contractors shall submit a report to the
1712 Chairmen of the House and Senate Medicaid Committees on the status
1713 of the uniform credentialing process for providers that is
1714 required under this subparagraph (a).

1715 (b) If those contractors have not implemented a
1716 uniform credentialing process as described in subparagraph (a) by
1717 December 1, 2021, the division shall develop and implement, not
1718 later than July 1, 2022, a single, consolidated credentialing



1719 process by which all providers will be credentialed. Under the
1720 division's single, consolidated credentialing process, no such
1721 contractor shall require its providers to be separately
1722 credentialed by the contractor in order to receive reimbursement
1723 from the contractor, but those contractors shall recognize the
1724 credentialing of the providers by the division's credentialing
1725 process.

1726 (c) The division shall require a uniform provider
1727 credentialing application that shall be used in the credentialing
1728 process that is established under subparagraph (a) or (b). If the
1729 contractor or division, as applicable, has not approved or denied
1730 the provider credentialing application within sixty (60) days of
1731 receipt of the completed application that includes all required
1732 information necessary for credentialing, then the contractor or
1733 division, upon receipt of a written request from the applicant and
1734 within five (5) business days of its receipt, shall issue a
1735 temporary provider credential/enrollment to the applicant if the
1736 applicant has a valid Mississippi professional or occupational
1737 license to provide the health care services to which the
1738 credential/enrollment would apply. The contractor or the division
1739 shall not issue a temporary credential/enrollment if the applicant
1740 has reported on the application a history of medical or other
1741 professional or occupational malpractice claims, a history of
1742 substance abuse or mental health issues, a criminal record, or a
1743 history of medical or other licensing board, state or federal



1744 disciplinary action, including any suspension from participation
1745 in a federal or state program. The temporary
1746 credential/enrollment shall be effective upon issuance and shall
1747 remain in effect until the provider's credentialing/enrollment
1748 application is approved or denied by the contractor or division.
1749 The contractor or division shall render a final decision regarding
1750 credentialing/enrollment of the provider within sixty (60) days
1751 from the date that the temporary provider credential/enrollment is
1752 issued to the applicant.

1753 (d) If the contractor or division does not render
1754 a final decision regarding credentialing/enrollment of the
1755 provider within the time required in subparagraph (c), the
1756 provider shall be deemed to be credentialed by and enrolled with
1757 all of the contractors and eligible to receive reimbursement from
1758 the contractors.

1759 (7) (a) Each contractor that is receiving capitated
1760 payments under a managed care delivery system established under
1761 this subsection (H) shall provide to each provider for whom the
1762 contractor has denied the coverage of a procedure that was ordered
1763 or requested by the provider for or on behalf of a patient, a
1764 letter that provides a detailed explanation of the reasons for the
1765 denial of coverage of the procedure and the name and the
1766 credentials of the person who denied the coverage. The letter
1767 shall be sent to the provider in electronic format.



1768 (b) After a contractor that is receiving capitated
1769 payments under a managed care delivery system established under
1770 this subsection (H) has denied coverage for a claim submitted by a
1771 provider, the contractor shall issue to the provider within sixty
1772 (60) days a final ruling of denial of the claim that allows the
1773 provider to have a state fair hearing and/or agency appeal with
1774 the division. If a contractor does not issue a final ruling of
1775 denial within sixty (60) days as required by this subparagraph
1776 (b), the provider's claim shall be deemed to be automatically
1777 approved and the contractor shall pay the amount of the claim to
1778 the provider.

1779 (c) After a contractor has issued a final ruling
1780 of denial of a claim submitted by a provider, the division shall
1781 conduct a state fair hearing and/or agency appeal on the matter of
1782 the disputed claim between the contractor and the provider within
1783 sixty (60) days, and shall render a decision on the matter within
1784 thirty (30) days after the date of the hearing and/or appeal.

1785 (8) It is the intention of the Legislature that the
1786 division evaluate the feasibility of using a single vendor to
1787 administer pharmacy benefits provided under a managed care
1788 delivery system established under this subsection (H). Providers
1789 of pharmacy benefits shall cooperate with the division in any
1790 transition to a carve-out of pharmacy benefits under managed care.

1791 (9) The division shall evaluate the feasibility of
1792 using a single vendor to administer dental benefits provided under



1793 a managed care delivery system established in this subsection (H).
1794 Providers of dental benefits shall cooperate with the division in
1795 any transition to a carve-out of dental benefits under managed
1796 care.

1797 (10) It is the intent of the Legislature that any
1798 contractor receiving capitated payments under a managed care
1799 delivery system established in this section shall implement
1800 innovative programs to improve the health and well-being of
1801 members diagnosed with prediabetes and diabetes.

1802 (11) It is the intent of the Legislature that any
1803 contractors receiving capitated payments under a managed care
1804 delivery system established under this subsection (H) shall work
1805 with providers of Medicaid services to improve the utilization of
1806 long-acting reversible contraceptives (LARCs). Not later than
1807 December 1, 2021, any contractors receiving capitated payments
1808 under a managed care delivery system established under this
1809 subsection (H) shall provide to the Chairmen of the House and
1810 Senate Medicaid Committees and House and Senate Public Health
1811 Committees a report of LARC utilization for State Fiscal Years
1812 2018 through 2020 as well as any programs, initiatives, or efforts
1813 made by the contractors and providers to increase LARC
1814 utilization. This report shall be updated annually to include
1815 information for subsequent state fiscal years.

1816 (12) The division is authorized to make not more than
1817 one (1) emergency extension of the contracts that are in effect on



1818 July 1, 2021, with contractors who are receiving capitated
1819 payments under a managed care delivery system established under
1820 this subsection (H), as provided in this paragraph (12). The
1821 maximum period of any such extension shall be one (1) year, and
1822 under any such extensions, the contractors shall be subject to all
1823 of the provisions of this subsection (H). The extended contracts
1824 shall be revised to incorporate any provisions of this subsection
1825 (H).

1826 (I) [Deleted]

1827 (J) There shall be no cuts in inpatient and outpatient
1828 hospital payments, or allowable days or volumes, as long as the
1829 hospital assessment provided in Section 43-13-145 is in effect.
1830 This subsection (J) shall not apply to decreases in payments that
1831 are a result of: reduced hospital admissions, audits or payments
1832 under the APR-DRG or APC models, or a managed care program or
1833 similar model described in subsection (H) of this section.

1834 (K) In the negotiation and execution of such contracts
1835 involving services performed by actuarial firms, the Executive
1836 Director of the Division of Medicaid may negotiate a limitation on
1837 liability to the state of prospective contractors.

1838 (L) The Division of Medicaid shall reimburse for services
1839 provided to eligible Medicaid beneficiaries by a licensed birthing
1840 center in a method and manner to be determined by the division in
1841 accordance with federal laws and federal regulations. The
1842 division shall seek any necessary waivers, make any required



1843 amendments to its State Plan or revise any contracts authorized
1844 under subsection (H) of this section as necessary to provide the
1845 services authorized under this subsection. As used in this
1846 subsection, the term "birthing centers" shall have the meaning as
1847 defined in Section 41-77-1(a), which is a publicly or privately
1848 owned facility, place or institution constructed, renovated,
1849 leased or otherwise established where nonemergency births are
1850 planned to occur away from the mother's usual residence following
1851 a documented period of prenatal care for a normal uncomplicated
1852 pregnancy which has been determined to be low risk through a
1853 formal risk-scoring examination.

1854 (M) This section shall stand repealed on July 1, * * *~~2028~~
1855 2029.

1856 **SECTION 3.** Section 43-13-121, Mississippi Code of 1972, is
1857 amended as follows:

1858 43-13-121. (1) The division shall administer the Medicaid
1859 program under the provisions of this article, and may do the
1860 following:

1861 (a) Adopt and promulgate reasonable rules, regulations
1862 and standards, with approval of the Governor, and in accordance
1863 with the Administrative Procedures Law, Section 25-43-1.101 et
1864 seq.:

1865 (i) Establishing methods and procedures as may be
1866 necessary for the proper and efficient administration of this
1867 article;



1868 (ii) Providing Medicaid to all qualified
1869 recipients under the provisions of this article as the division
1870 may determine and within the limits of appropriated funds;
1871 (iii) Establishing reasonable fees, charges and
1872 rates for medical services and drugs; in doing so, the division
1873 shall fix all of those fees, charges and rates at the minimum
1874 levels absolutely necessary to provide the medical assistance
1875 authorized by this article, and shall not change any of those
1876 fees, charges or rates except as may be authorized in Section
1877 43-13-117;
1878 (iv) Providing for fair and impartial hearings;
1879 (v) Providing safeguards for preserving the
1880 confidentiality of records; and
1881 (vi) For detecting and processing fraudulent
1882 practices and abuses of the program;
1883 (b) Receive and expend state, federal and other funds
1884 in accordance with court judgments or settlements and agreements
1885 between the State of Mississippi and the federal government, the
1886 rules and regulations promulgated by the division, with the
1887 approval of the Governor, and within the limitations and
1888 restrictions of this article and within the limits of funds
1889 available for that purpose;
1890 (c) Subject to the limits imposed by this article and
1891 subject to the provisions of subsection (8) of this section, to
1892 submit a Medicaid plan to the United States Department of Health



1893 and Human Services for approval under the provisions of the
1894 federal Social Security Act, to act for the state in making
1895 negotiations relative to the submission and approval of that plan,
1896 to make such arrangements, not inconsistent with the law, as may
1897 be required by or under federal law to obtain and retain that
1898 approval and to secure for the state the benefits of the
1899 provisions of that law.

1900 No agreements, specifically including the general plan for
1901 the operation of the Medicaid program in this state, shall be made
1902 by and between the division and the United States Department of
1903 Health and Human Services unless the Attorney General of the State
1904 of Mississippi has reviewed the agreements, specifically including
1905 the operational plan, and has certified in writing to the Governor
1906 and to the executive director of the division that the agreements,
1907 including the plan of operation, have been drawn strictly in
1908 accordance with the terms and requirements of this article;

1909 (d) In accordance with the purposes and intent of this
1910 article and in compliance with its provisions, provide for aged
1911 persons otherwise eligible for the benefits provided under Title
1912 XVIII of the federal Social Security Act by expenditure of funds
1913 available for those purposes;

1914 (e) To make reports to the United States Department of
1915 Health and Human Services as from time to time may be required by
1916 that federal department and to the Mississippi Legislature as
1917 provided in this section;



1918 (f) Define and determine the scope, duration and amount
1919 of Medicaid that may be provided in accordance with this article
1920 and establish priorities therefor in conformity with this article;

1921 (g) Cooperate and contract with other state agencies
1922 for the purpose of coordinating Medicaid provided under this
1923 article and eliminating duplication and inefficiency in the
1924 Medicaid program;

1925 (h) Adopt and use an official seal of the division;

1926 (i) Sue in its own name on behalf of the State of
1927 Mississippi and employ legal counsel on a contingency basis with
1928 the approval of the Attorney General;

1929 (j) To recover any and all payments incorrectly made by
1930 the division to a recipient or provider from the recipient or
1931 provider receiving the payments. The division shall be authorized
1932 to collect any overpayments to providers sixty (60) days after the
1933 conclusion of any administrative appeal unless the matter is
1934 appealed to a court of proper jurisdiction and bond is posted.
1935 Any appeal filed after July 1, 2015, shall be to the Chancery
1936 Court of the First Judicial District of Hinds County, Mississippi,
1937 within sixty (60) days after the date that the division has
1938 notified the provider by certified mail sent to the proper address
1939 of the provider on file with the division and the provider has
1940 signed for the certified mail notice, or sixty (60) days after the
1941 date of the final decision if the provider does not sign for the
1942 certified mail notice. To recover those payments, the division



1943 may use the following methods, in addition to any other methods
1944 available to the division:

1945 (i) The division shall report to the Department of
1946 Revenue the name of any current or former Medicaid recipient who
1947 has received medical services rendered during a period of
1948 established Medicaid ineligibility and who has not reimbursed the
1949 division for the related medical service payment(s). The
1950 Department of Revenue shall withhold from the state tax refund of
1951 the individual, and pay to the division, the amount of the
1952 payment(s) for medical services rendered to the ineligible
1953 individual that have not been reimbursed to the division for the
1954 related medical service payment(s).

1955 (ii) The division shall report to the Department
1956 of Revenue the name of any Medicaid provider to whom payments were
1957 incorrectly made that the division has not been able to recover by
1958 other methods available to the division. The Department of
1959 Revenue shall withhold from the state tax refund of the provider,
1960 and pay to the division, the amount of the payments that were
1961 incorrectly made to the provider that have not been recovered by
1962 other available methods;

1963 (k) To recover any and all payments by the division
1964 fraudulently obtained by a recipient or provider. Additionally,
1965 if recovery of any payments fraudulently obtained by a recipient
1966 or provider is made in any court, then, upon motion of the



1967 Governor, the judge of the court may award twice the payments
1968 recovered as damages;

1969 (1) Have full, complete and plenary power and authority
1970 to conduct such investigations as it may deem necessary and
1971 requisite of alleged or suspected violations or abuses of the
1972 provisions of this article or of the regulations adopted under
1973 this article, including, but not limited to, fraudulent or
1974 unlawful act or deed by applicants for Medicaid or other benefits,
1975 or payments made to any person, firm or corporation under the
1976 terms, conditions and authority of this article, to suspend or
1977 disqualify any provider of services, applicant or recipient for
1978 gross abuse, fraudulent or unlawful acts for such periods,
1979 including permanently, and under such conditions as the division
1980 deems proper and just, including the imposition of a legal rate of
1981 interest on the amount improperly or incorrectly paid. Recipients
1982 who are found to have misused or abused Medicaid benefits may be
1983 locked into one (1) physician and/or one (1) pharmacy of the
1984 recipient's choice for a reasonable amount of time in order to
1985 educate and promote appropriate use of medical services, in
1986 accordance with federal regulations. If an administrative hearing
1987 becomes necessary, the division may, if the provider does not
1988 succeed in his or her defense, tax the costs of the administrative
1989 hearing, including the costs of the court reporter or stenographer
1990 and transcript, to the provider. The convictions of a recipient
1991 or a provider in a state or federal court for abuse, fraudulent or



1992 unlawful acts under this chapter shall constitute an automatic
1993 disqualification of the recipient or automatic disqualification of
1994 the provider from participation under the Medicaid program.

1995 A conviction, for the purposes of this chapter, shall include
1996 a judgment entered on a plea of nolo contendere or a
1997 nonadjudicated guilty plea and shall have the same force as a
1998 judgment entered pursuant to a guilty plea or a conviction
1999 following trial. A certified copy of the judgment of the court of
2000 competent jurisdiction of the conviction shall constitute prima
2001 facie evidence of the conviction for disqualification purposes;

2002 (m) Establish and provide such methods of
2003 administration as may be necessary for the proper and efficient
2004 operation of the Medicaid program, fully utilizing computer
2005 equipment as may be necessary to oversee and control all current
2006 expenditures for purposes of this article, and to closely monitor
2007 and supervise all recipient payments and vendors rendering
2008 services under this article. Notwithstanding any other provision
2009 of state law, the division is authorized to enter into a ten-year
2010 contract(s) with a vendor(s) to provide services described in this
2011 paragraph (m). Notwithstanding any provision of law to the
2012 contrary, the division is authorized to extend its Medicaid
2013 Management Information System, including all related components
2014 and services, and Decision Support System, including all related
2015 components and services, contracts in effect on June 30, 2020, for



2016 a period not to exceed two (2) years without complying with state
2017 procurement regulations;

2018 (n) To cooperate and contract with the federal
2019 government for the purpose of providing Medicaid to Vietnamese and
2020 Cambodian refugees, under the provisions of Public Law 94-23 and
2021 Public Law 94-24, including any amendments to those laws, only to
2022 the extent that the Medicaid assistance and the administrative
2023 cost related thereto are one hundred percent (100%) reimbursable
2024 by the federal government. For the purposes of Section 43-13-117,
2025 persons receiving Medicaid under Public Law 94-23 and Public Law
2026 94-24, including any amendments to those laws, shall not be
2027 considered a new group or category of recipient; and

2028 (o) The division shall impose penalties upon Medicaid
2029 only, Title XIX participating long-term care facilities found to
2030 be in noncompliance with division and certification standards in
2031 accordance with federal and state regulations, including interest
2032 at the same rate calculated by the United States Department of
2033 Health and Human Services and/or the Centers for Medicare and
2034 Medicaid Services (CMS) under federal regulations.

2035 (2) The division also shall exercise such additional powers
2036 and perform such other duties as may be conferred upon the
2037 division by act of the Legislature.

2038 (3) The division, and the State Department of Health as the
2039 agency for licensure of health care facilities and certification
2040 and inspection for the Medicaid and/or Medicare programs, shall



2041 contract for or otherwise provide for the consolidation of on-site
2042 inspections of health care facilities that are necessitated by the
2043 respective programs and functions of the division and the
2044 department.

2045 (4) The division and its hearing officers shall have power
2046 to preserve and enforce order during hearings; to issue subpoenas
2047 for, to administer oaths to and to compel the attendance and
2048 testimony of witnesses, or the production of books, papers,
2049 documents and other evidence, or the taking of depositions before
2050 any designated individual competent to administer oaths; to
2051 examine witnesses; and to do all things conformable to law that
2052 may be necessary to enable them effectively to discharge the
2053 duties of their office. In compelling the attendance and
2054 testimony of witnesses, or the production of books, papers,
2055 documents and other evidence, or the taking of depositions, as
2056 authorized by this section, the division or its hearing officers
2057 may designate an individual employed by the division or some other
2058 suitable person to execute and return that process, whose action
2059 in executing and returning that process shall be as lawful as if
2060 done by the sheriff or some other proper officer authorized to
2061 execute and return process in the county where the witness may
2062 reside. In carrying out the investigatory powers under the
2063 provisions of this article, the executive director or other
2064 designated person or persons may examine, obtain, copy or
2065 reproduce the books, papers, documents, medical charts,



2066 prescriptions and other records relating to medical care and
2067 services furnished by the provider to a recipient or designated
2068 recipients of Medicaid services under investigation. In the
2069 absence of the voluntary submission of the books, papers,
2070 documents, medical charts, prescriptions and other records, the
2071 Governor, the executive director, or other designated person may
2072 issue and serve subpoenas instantly upon the provider, his or her
2073 agent, servant or employee for the production of the books,
2074 papers, documents, medical charts, prescriptions or other records
2075 during an audit or investigation of the provider. If any provider
2076 or his or her agent, servant or employee refuses to produce the
2077 records after being duly subpoenaed, the executive director may
2078 certify those facts and institute contempt proceedings in the
2079 manner, time and place as authorized by law for administrative
2080 proceedings. As an additional remedy, the division may recover
2081 all amounts paid to the provider covering the period of the audit
2082 or investigation, inclusive of a legal rate of interest and a
2083 reasonable attorney's fee and costs of court if suit becomes
2084 necessary. Division staff shall have immediate access to the
2085 provider's physical location, facilities, records, documents,
2086 books, and any other records relating to medical care and services
2087 rendered to recipients during regular business hours.

2088 (5) If any person in proceedings before the division
2089 disobeys or resists any lawful order or process, or misbehaves
2090 during a hearing or so near the place thereof as to obstruct the



2091 hearing, or neglects to produce, after having been ordered to do
2092 so, any pertinent book, paper or document, or refuses to appear
2093 after having been subpoenaed, or upon appearing refuses to take
2094 the oath as a witness, or after having taken the oath refuses to
2095 be examined according to law, the executive director shall certify
2096 the facts to any court having jurisdiction in the place in which
2097 it is sitting, and the court shall thereupon, in a summary manner,
2098 hear the evidence as to the acts complained of, and if the
2099 evidence so warrants, punish that person in the same manner and to
2100 the same extent as for a contempt committed before the court, or
2101 commit that person upon the same condition as if the doing of the
2102 forbidden act had occurred with reference to the process of, or in
2103 the presence of, the court.

2104 (6) In suspending or terminating any provider from
2105 participation in the Medicaid program, the division shall preclude
2106 the provider from submitting claims for payment, either personally
2107 or through any clinic, group, corporation or other association to
2108 the division or its fiscal agents for any services or supplies
2109 provided under the Medicaid program except for those services or
2110 supplies provided before the suspension or termination. No
2111 clinic, group, corporation or other association that is a provider
2112 of services shall submit claims for payment to the division or its
2113 fiscal agents for any services or supplies provided by a person
2114 within that organization who has been suspended or terminated from
2115 participation in the Medicaid program except for those services or



2116 supplies provided before the suspension or termination. When this
2117 provision is violated by a provider of services that is a clinic,
2118 group, corporation or other association, the division may suspend
2119 or terminate that organization from participation. Suspension may
2120 be applied by the division to all known affiliates of a provider,
2121 provided that each decision to include an affiliate is made on a
2122 case-by-case basis after giving due regard to all relevant facts
2123 and circumstances. The violation, failure or inadequacy of
2124 performance may be imputed to a person with whom the provider is
2125 affiliated where that conduct was accomplished within the course
2126 of his or her official duty or was effectuated by him or her with
2127 the knowledge or approval of that person.

2128 (7) The division may deny or revoke enrollment in the
2129 Medicaid program to a provider if any of the following are found
2130 to be applicable to the provider, his or her agent, a managing
2131 employee or any person having an ownership interest equal to five
2132 percent (5%) or greater in the provider:

2133 (a) Failure to truthfully or fully disclose any and all
2134 information required, or the concealment of any and all
2135 information required, on a claim, a provider application or a
2136 provider agreement, or the making of a false or misleading
2137 statement to the division relative to the Medicaid program.

2138 (b) Previous or current exclusion, suspension,
2139 termination from or the involuntary withdrawing from participation
2140 in the Medicaid program, any other state's Medicaid program,



2141 Medicare or any other public or private health or health insurance
2142 program. If the division ascertains that a provider has been
2143 convicted of a felony under federal or state law for an offense
2144 that the division determines is detrimental to the best interest
2145 of the program or of Medicaid beneficiaries, the division may
2146 refuse to enter into an agreement with that provider, or may
2147 terminate or refuse to renew an existing agreement.

2148 (c) Conviction under federal or state law of a criminal
2149 offense relating to the delivery of any goods, services or
2150 supplies, including the performance of management or
2151 administrative services relating to the delivery of the goods,
2152 services or supplies, under the Medicaid program, any other
2153 state's Medicaid program, Medicare or any other public or private
2154 health or health insurance program.

2155 (d) Conviction under federal or state law of a criminal
2156 offense relating to the neglect or abuse of a patient in
2157 connection with the delivery of any goods, services or supplies.

2158 (e) Conviction under federal or state law of a criminal
2159 offense relating to the unlawful manufacture, distribution,
2160 prescription or dispensing of a controlled substance.

2161 (f) Conviction under federal or state law of a criminal
2162 offense relating to fraud, theft, embezzlement, breach of
2163 fiduciary responsibility or other financial misconduct.



2164 (g) Conviction under federal or state law of a criminal
2165 offense punishable by imprisonment of a year or more that involves
2166 moral turpitude, or acts against the elderly, children or infirm.

2167 (h) Conviction under federal or state law of a criminal
2168 offense in connection with the interference or obstruction of any
2169 investigation into any criminal offense listed in paragraphs (c)
2170 through (i) of this subsection.

2171 (i) Sanction for a violation of federal or state laws
2172 or rules relative to the Medicaid program, any other state's
2173 Medicaid program, Medicare or any other public health care or
2174 health insurance program.

2175 (j) Revocation of license or certification.

2176 (k) Failure to pay recovery properly assessed or
2177 pursuant to an approved repayment schedule under the Medicaid
2178 program.

2179 (l) Failure to meet any condition of enrollment.

2180 (8) (a) As used in this subsection (8), the following terms
2181 shall be defined as provided in this paragraph, except as
2182 otherwise provided in this subsection:

2183 (i) "Committees" means the Medicaid Committees of
2184 the House of Representatives and the Senate, and "committee" means
2185 either one of those committees.

2186 (ii) "State Plan" means the agreement between the
2187 State of Mississippi and the federal government regarding the
2188 nature and scope of Mississippi's Medicaid Program.



2189 (iii) "State Plan Amendment" means a change to the
2190 State Plan, which must be approved by the Centers for Medicare and
2191 Medicaid Services (CMS) before its implementation.

2192 (b) Whenever the Division of Medicaid proposes a State
2193 Plan Amendment, the division shall give notice to the chairmen of
2194 the committees at least * * * ~~thirty (30)~~ fifteen (15) calendar
2195 days before the proposed State Plan Amendment is filed with CMS.
2196 The division shall furnish the chairmen with a concise summary of
2197 each proposed State Plan Amendment along with the notice, and
2198 shall furnish the chairmen with a copy of any proposed State Plan
2199 Amendment upon request. The division also shall provide a summary
2200 and copy of any proposed State Plan Amendment to any other member
2201 of the Legislature upon request.

2202 (c) If the chairman of either committee or both
2203 chairmen jointly object to the proposed State Plan Amendment or
2204 any part thereof, the chairman or chairmen shall notify the
2205 division and provide the reasons for their objection in writing
2206 not later than seven (7) calendar days after receipt of the notice
2207 from the division. The chairman or chairmen may make written
2208 recommendations to the division for changes to be made to a
2209 proposed State Plan Amendment.

2210 (d) (i) The chairman of either committee or both
2211 chairmen jointly may hold a committee meeting to review a proposed
2212 State Plan Amendment. If either chairman or both chairmen decide
2213 to hold a meeting, they shall notify the division of their



2214 intention in writing within seven (7) calendar days after receipt
2215 of the notice from the division, and shall set the date and time
2216 for the meeting in their notice to the division, which shall not
2217 be later than fourteen (14) calendar days after receipt of the
2218 notice from the division.

2219 (ii) After the committee meeting, the committee or
2220 committees may object to the proposed State Plan Amendment or any
2221 part thereof. The committee or committees shall notify the
2222 division and the reasons for their objection in writing not later
2223 than seven (7) calendar days after the meeting. The committee or
2224 committees may make written recommendations to the division for
2225 changes to be made to a proposed State Plan Amendment.

2226 (e) If both chairmen notify the division in writing
2227 within seven (7) calendar days after receipt of the notice from
2228 the division that they do not object to the proposed State Plan
2229 Amendment and will not be holding a meeting to review the proposed
2230 State Plan Amendment, the division may proceed to file the
2231 proposed State Plan Amendment with CMS.

2232 (f) (i) If there are any objections to a proposed rate
2233 change or any part thereof from either or both of the chairmen or
2234 the committees, the division may withdraw the proposed State Plan
2235 Amendment, make any of the recommended changes to the proposed
2236 State Plan Amendment, or not make any changes to the proposed
2237 State Plan Amendment.



2238 (ii) If the division does not make any changes to
2239 the proposed State Plan Amendment, it shall notify the chairmen of
2240 that fact in writing, and may proceed to file the State Plan
2241 Amendment with CMS.

2242 (iii) If the division makes any changes to the
2243 proposed State Plan Amendment, the division shall notify the
2244 chairmen of its actions in writing, and may proceed to file the
2245 State Plan Amendment with CMS.

2246 (g) Nothing in this subsection (8) shall be construed
2247 as giving the chairmen or the committees any authority to veto,
2248 nullify or revise any State Plan Amendment proposed by the
2249 division. The authority of the chairmen or the committees under
2250 this subsection shall be limited to reviewing, making objections
2251 to and making recommendations for changes to State Plan Amendments
2252 proposed by the division.

2253 (i) If the division does not make any changes to
2254 the proposed State Plan Amendment, it shall notify the chairmen of
2255 that fact in writing, and may proceed to file the proposed State
2256 Plan Amendment with CMS.

2257 (ii) If the division makes any changes to the
2258 proposed State Plan Amendment, the division shall notify the
2259 chairmen of the changes in writing, and may proceed to file the
2260 proposed State Plan Amendment with CMS.



2261 (iii) If the division needs to expedite the
2262 fifteen-day legislative notice set forth in paragraph (b) of this
2263 subsection (8), the division will notify both chairmen.

2264 (h) Nothing in this subsection (8) shall be construed
2265 as giving the chairmen of the committees any authority to veto,
2266 nullify or revise any State Plan Amendment proposed by the
2267 division. The authority of the chairmen of the committees under
2268 this subsection shall be limited to reviewing, making objections
2269 to and making recommendations for suggested changes to State Plan
2270 Amendments proposed by the division.

2271 **SECTION 4.** Section 43-13-305, Mississippi Code of 1972, is
2272 amended as follows:

2273 43-13-305. (1) By accepting Medicaid from the Division of
2274 Medicaid in the Office of the Governor, the recipient shall, to
2275 the extent of the payment of medical expenses by the Division of
2276 Medicaid, be deemed to have made an assignment to the Division of
2277 Medicaid of any and all rights and interests in any third-party
2278 benefits, hospitalization or indemnity contract or any cause of
2279 action, past, present or future, against any person, firm or
2280 corporation for Medicaid benefits provided to the recipient by the
2281 Division of Medicaid for injuries, disease or sickness caused or
2282 suffered under circumstances creating a cause of action in favor
2283 of the recipient against any such person, firm or corporation as
2284 set out in Section 43-13-125. The recipient shall be deemed,
2285 without the necessity of signing any document, to have appointed



2286 the Division of Medicaid as his or her true and lawful
2287 attorney-in-fact in his or her name, place and stead in collecting
2288 any and all amounts due and owing for medical expenses paid by the
2289 Division of Medicaid against such person, firm or corporation.

2290 (2) Whenever a provider of medical services or the Division
2291 of Medicaid submits claims to an insurer on behalf of a Medicaid
2292 recipient for whom an assignment of rights has been received, or
2293 whose rights have been assigned by the operation of law, the
2294 insurer must respond within sixty (60) days of receipt of a claim
2295 by forwarding payment or issuing a notice of denial directly to
2296 the submitter of the claim. The failure of the insuring entity to
2297 comply with the provisions of this section shall subject the
2298 insuring entity to recourse by the Division of Medicaid in
2299 accordance with the provision of Section 43-13-315. In the case
2300 of a responsible insurer, other than the insurers exempted under
2301 federal law, that requires prior authorization for an item or
2302 service furnished to a recipient, the insurer shall accept
2303 authorization provided by the Division of Medicaid that the item
2304 or service is covered under the state plan (or waiver of such
2305 plan) for such recipient, as if such authorization were the prior
2306 authorization made by the third party for such item or service.

2307 The Division of Medicaid shall be authorized to endorse any and
2308 all, including, but not limited to, multi-payee checks, drafts,
2309 money orders or other negotiable instruments representing Medicaid
2310 payment recoveries that are received by the Division of Medicaid.



2311 (3) Court orders or agreements for medical support shall
2312 direct such payments to the Division of Medicaid, which shall be
2313 authorized to endorse any and all checks, drafts, money orders or
2314 other negotiable instruments representing medical support payments
2315 which are received. Any designated medical support funds received
2316 by the State Department of Human Services or through its local
2317 county departments shall be paid over to the Division of Medicaid.
2318 When medical support for a Medicaid recipient is available through
2319 an absent parent or custodial parent, the insuring entity shall
2320 direct the medical support payment(s) to the provider of medical
2321 services or to the Division of Medicaid.

2322 **SECTION 5.** Section 43-11-1, Mississippi Code of 1972, is
2323 amended as follows:

2324 43-11-1. When used in this chapter, the following words
2325 shall have the following meaning:

2326 (a) "Institutions for the aged or infirm" means a place
2327 either governmental or private that provides group living
2328 arrangements for four (4) or more persons who are unrelated to the
2329 operator and who are being provided food, shelter and personal
2330 care, whether any such place is organized or operated for profit
2331 or not. The term "institution for the aged or infirm" includes
2332 nursing homes, pediatric skilled nursing facilities, psychiatric
2333 residential treatment facilities, convalescent homes, homes for
2334 the aged, adult foster care facilities and special care facilities
2335 for paroled inmates, provided that these institutions fall within



2336 the scope of the definitions set forth above. The term
2337 "institution for the aged or infirm" does not include hospitals,
2338 clinics or mental institutions devoted primarily to providing
2339 medical service, and does not include any private residence in
2340 which the owner of the residence is providing personal care
2341 services to disabled or homeless veterans under an agreement with,
2342 and in compliance with the standards prescribed by, the United
2343 States Department of Veterans Affairs, if the owner of the
2344 residence also provided personal care services to disabled or
2345 homeless veterans at any time during calendar year 2008.

2346 (b) "Person" means any individual, firm, partnership,
2347 corporation, company, association or joint-stock association, or
2348 any licensee herein or the legal successor thereof.

2349 (c) "Personal care" means assistance rendered by
2350 personnel of the home to aged or infirm residents in performing
2351 one or more of the activities of daily living, which includes, but
2352 is not limited to, the bathing, walking, excretory functions,
2353 feeding, personal grooming and dressing of such residents.

2354 (d) "Psychiatric residential treatment facility" means
2355 any nonhospital establishment with permanent facilities which
2356 provides a twenty-four-hour program of care by qualified
2357 therapists, including, but not limited to, duly licensed mental
2358 health professionals, psychiatrists, psychologists,
2359 psychotherapists and licensed certified social workers, for
2360 emotionally disturbed children and adolescents referred to such



2361 facility by a court, local school district or by the Department of
2362 Human Services, who are not in an acute phase of illness requiring
2363 the services of a psychiatric hospital, and are in need of such
2364 restorative treatment services. For purposes of this paragraph,
2365 the term "emotionally disturbed" means a condition exhibiting one
2366 or more of the following characteristics over a long period of
2367 time and to a marked degree, which adversely affects educational
2368 performance:

2369 1. An inability to learn which cannot be explained
2370 by intellectual, sensory or health factors;

2371 2. An inability to build or maintain satisfactory
2372 relationships with peers and teachers;

2373 3. Inappropriate types of behavior or feelings
2374 under normal circumstances;

2375 4. A general pervasive mood of unhappiness or
2376 depression; or

2377 5. A tendency to develop physical symptoms or
2378 fears associated with personal or school problems. An
2379 establishment furnishing primarily domiciliary care is not within
2380 this definition.

2381 (e) "Pediatric skilled nursing facility" means an
2382 institution or a distinct part of an institution that is primarily
2383 engaged in providing to inpatients skilled nursing care and
2384 related services for persons under twenty-one (21) years of age



2385 who require medical or nursing care or rehabilitation services for
2386 the rehabilitation of injured, disabled or sick persons.

2387 (f) "Licensing agency" means the State Department of
2388 Health.

2389 (g) "Medical records" mean, without restriction, those
2390 medical histories, records, reports, summaries, diagnoses and
2391 prognoses, records of treatment and medication ordered and given,
2392 notes, entries, x-rays and other written or graphic data prepared,
2393 kept, made or maintained in institutions for the aged or infirm
2394 that pertain to residency in, or services rendered to residents
2395 of, an institution for the aged or infirm.

2396 (h) "Adult foster care facility" means a home setting
2397 for vulnerable adults in the community who are unable to live
2398 independently due to physical, emotional, developmental or mental
2399 impairments, or in need of emergency and continuing protective
2400 social services for purposes of preventing further abuse or
2401 neglect and for safeguarding and enhancing the welfare of the
2402 abused or neglected vulnerable adult. Adult foster care programs
2403 shall be designed to meet the needs of vulnerable adults with
2404 impairments through individual plans of care, which provide a
2405 variety of health, social and related support services in a
2406 protective setting, enabling participants to live in the
2407 community. Adult foster care programs may be (i) traditional,
2408 where the foster care provider lives in the residence and is the
2409 primary caregiver to clients in the home; (ii) corporate, where



2410 the foster care home is operated by a corporation with shift staff
2411 delivering services to clients; or (iii) shelter, where the foster
2412 care home accepts clients on an emergency short-term basis for up
2413 to thirty (30) days.

2414 (i) "Special care facilities for paroled inmates" means
2415 long-term care and skilled nursing facilities licensed as special
2416 care facilities for medically frail paroled inmates, formed to
2417 ease the burden of prison overcrowding and provide compassionate
2418 release and medical parole initiatives while impacting economic
2419 outcomes for the Mississippi prison system. The facilities shall
2420 meet all Mississippi Department of Health and federal Center for
2421 Medicaid Services (CMS) requirements and shall be regulated by
2422 both agencies; provided, however, such regulations shall not be as
2423 restrictive as those required for personal care homes and other
2424 institutions devoted primarily to providing medical services. The
2425 facilities will offer physical, occupational and speech therapy,
2426 nursing services, wound care, a dedicated COVID services unit,
2427 individualized patient centered plans of care, social services,
2428 spiritual services, physical activities, transportation,
2429 medication, durable medical equipment, personalized meal plans by
2430 a licensed dietician and security services. There may be up to
2431 three (3) facilities located in each Supreme Court district, to be
2432 designated by the Chairman of the State Parole Board or his
2433 designee.



2434 (j) "Adult day care facility" means a public agency or
2435 private organization, or a subdivision of such an agency or
2436 organization, that:

2437 (i) Provides the following items and services:

2438 1. Nursing services;

2439 2. Transportation of the individual to and
2440 from such adult day care facility in connection with any such item
2441 or service;

2442 3. Meals;

2443 4. A program of supervised activities that
2444 meets such criteria as the licensing agency determines and is
2445 appropriately designed to promote physical and mental health that
2446 is furnished to the individual by such a facility in a group
2447 setting for a period not greater than twelve (12) hours per day;

2448 5. The administration of medication by a
2449 licensed nurse, and a medication management program to minimize
2450 unnecessary or inappropriate use of prescription drugs and adverse
2451 events due to unintended prescription drug-to-drug interactions;
2452 and

2453 (ii) Meets such standards established by the
2454 licensing agency to assure quality of care and such other
2455 requirements as the licensing agency finds necessary in the
2456 interest of the health and safety of individuals who are furnished
2457 services in the facility.



2458 **SECTION 6.** Section 43-11-8, Mississippi Code of 1972, is
2459 amended as follows:

2460 43-11-8. (1) An application for a license for an adult
2461 foster care facility or for an adult day care facility shall be
2462 made to the licensing agency upon forms provided by it and shall
2463 contain such information as the licensing agency reasonably
2464 requires, which may include affirmative evidence of ability to
2465 comply with such reasonable standards, rules and regulations as
2466 are lawfully prescribed hereunder. Each application for a license
2467 for an adult foster care facility or for an adult day care
2468 facility shall be accompanied by a license fee of Ten Dollars
2469 (\$10.00) for each person or bed of licensed capacity, with a
2470 minimum fee per home or institution of Fifty Dollars (\$50.00),
2471 which shall be paid to the licensing agency. Any increase in the
2472 fee charged by the licensing agency under this subsection shall be
2473 in accordance with the provisions of Section 41-3-65.

2474 (2) A license, unless suspended or revoked, shall be
2475 renewable annually upon payment by the licensee of an adult foster
2476 care facility or of an adult day care facility, except for
2477 personal care homes, of a renewal fee of Ten Dollars (\$10.00) for
2478 each person or bed of licensed capacity in the institution, with a
2479 minimum renewal fee per institution of Fifty Dollars (\$50.00),
2480 which shall be paid to the licensing agency, and upon filing by
2481 the licensee and approval by the licensing agency of an annual
2482 report upon such uniform dates and containing such information in



2483 such form as the licensing agency prescribes by regulation. Any
2484 increase in the fee charged by the licensing agency under this
2485 subsection shall be in accordance with the provisions of Section
2486 41-3-65. Each license shall be issued only for the premises and
2487 person or persons or other legal entity or entities named in the
2488 application and shall not be transferable or assignable except
2489 with the written approval of the licensing agency. Licenses shall
2490 be posted in a conspicuous place on the licensed premises.

2491 **SECTION 7.** Section 43-11-13, Mississippi Code of 1972, is
2492 amended as follows:

2493 43-11-13. (1) The licensing agency shall adopt, amend,
2494 promulgate and enforce such rules, regulations and standards,
2495 including classifications, with respect to all institutions for
2496 the aged or infirm to be licensed under this chapter as may be
2497 designed to further the accomplishment of the purpose of this
2498 chapter in promoting adequate care of individuals in those
2499 institutions in the interest of public health, safety and welfare.
2500 Those rules, regulations and standards shall be adopted and
2501 promulgated by the licensing agency and shall be recorded and
2502 indexed in a book to be maintained by the licensing agency in its
2503 main office in the State of Mississippi, entitled "Rules,
2504 Regulations and Minimum Standards for Institutions for the Aged or
2505 Infirm" and the book shall be open and available to all
2506 institutions for the aged or infirm and the public generally at
2507 all reasonable times. Upon the adoption of those rules,



2508 regulations and standards, the licensing agency shall mail copies
2509 thereof to all those institutions in the state that have filed
2510 with the agency their names and addresses for this purpose, but
2511 the failure to mail the same or the failure of the institutions to
2512 receive the same shall in no way affect the validity thereof. The
2513 rules, regulations and standards may be amended by the licensing
2514 agency, from time to time, as necessary to promote the health,
2515 safety and welfare of persons living in those institutions.

2516 (2) The licensee shall keep posted in a conspicuous place on
2517 the licensed premises all current rules, regulations and minimum
2518 standards applicable to fire protection measures as adopted by the
2519 licensing agency. The licensee shall furnish to the licensing
2520 agency at least once each six (6) months a certificate of approval
2521 and inspection by state or local fire authorities. Failure to
2522 comply with state laws and/or municipal ordinances and current
2523 rules, regulations and minimum standards as adopted by the
2524 licensing agency, relative to fire prevention measures, shall be
2525 prima facie evidence for revocation of license.

2526 (3) The State Board of Health shall promulgate rules and
2527 regulations restricting the storage, quantity and classes of drugs
2528 allowed in personal care homes and adult foster care facilities.
2529 Residents requiring administration of Schedule II Narcotics as
2530 defined in the Uniform Controlled Substances Law may be admitted
2531 to a personal care home. Schedule drugs may only be allowed in a
2532 personal care home if they are administered or stored utilizing



2533 proper procedures under the direct supervision of a licensed
2534 physician or nurse.

2535 (4) (a) Notwithstanding any determination by the licensing
2536 agency that skilled nursing services would be appropriate for a
2537 resident of a personal care home, that resident, the resident's
2538 guardian or the legally recognized responsible party for the
2539 resident may consent in writing for the resident to continue to
2540 reside in the personal care home, if approved in writing by a
2541 licensed physician. However, no personal care home shall allow
2542 more than two (2) residents, or ten percent (10%) of the total
2543 number of residents in the facility, whichever is greater, to
2544 remain in the personal care home under the provisions of this
2545 subsection (4). This consent shall be deemed to be appropriately
2546 informed consent as described in the regulations promulgated by
2547 the licensing agency. After that written consent has been
2548 obtained, the resident shall have the right to continue to reside
2549 in the personal care home for as long as the resident meets the
2550 other conditions for residing in the personal care home. A copy
2551 of the written consent and the physician's approval shall be
2552 forwarded by the personal care home to the licensing agency.

2553 (b) The State Board of Health shall promulgate rules
2554 and regulations restricting the handling of a resident's personal
2555 deposits by the director of a personal care home. Any funds given
2556 or provided for the purpose of supplying extra comforts,
2557 conveniences or services to any resident in any personal care



2558 home, and any funds otherwise received and held from, for or on
2559 behalf of any such resident, shall be deposited by the director or
2560 other proper officer of the personal care home to the credit of
2561 that resident in an account that shall be known as the Resident's
2562 Personal Deposit Fund. No more than one (1) month's charge for
2563 the care, support, maintenance and medical attention of the
2564 resident shall be applied from the account at any one time. After
2565 the death, discharge or transfer of any resident for whose benefit
2566 any such fund has been provided, any unexpended balance remaining
2567 in his personal deposit fund shall be applied for the payment of
2568 care, cost of support, maintenance and medical attention that is
2569 accrued. If any unexpended balance remains in that resident's
2570 personal deposit fund after complete reimbursement has been made
2571 for payment of care, support, maintenance and medical attention,
2572 and the director or other proper officer of the personal care home
2573 has been or shall be unable to locate the person or persons
2574 entitled to the unexpended balance, the director or other proper
2575 officer may, after the lapse of one (1) year from the date of that
2576 death, discharge or transfer, deposit the unexpended balance to
2577 the credit of the personal care home's operating fund.

2578 (c) The State Board of Health shall promulgate rules
2579 and regulations requiring personal care homes to maintain records
2580 relating to health condition, medicine dispensed and administered,
2581 and any reaction to that medicine. The director of the personal
2582 care home shall be responsible for explaining the availability of



2583 those records to the family of the resident at any time upon
2584 reasonable request.

2585 (5) The State Board of Health and the Mississippi Department
2586 of Corrections shall jointly issue rules and regulations for the
2587 operation of the special care facilities for paroled inmates.

2588 (6) (a) For the purposes of this subsection (6):

2589 (i) "Licensed entity" means a hospital, nursing
2590 home, personal care home, home health agency, hospice or adult
2591 foster care facility;

2592 (ii) "Covered entity" means a licensed entity or a
2593 health care professional staffing agency;

2594 (iii) "Employee" means any individual employed by
2595 a covered entity, and also includes any individual who by contract
2596 provides to the patients, residents or clients being served by the
2597 covered entity direct, hands-on, medical patient care in a
2598 patient's, resident's or client's room or in treatment or recovery
2599 rooms. The term "employee" does not include health care
2600 professional/vocational technical students performing clinical
2601 training in a licensed entity under contracts between their
2602 schools and the licensed entity, and does not include students at
2603 high schools located in Mississippi who observe the treatment and
2604 care of patients in a licensed entity as part of the requirements
2605 of an allied-health course taught in the high school, if:

2606 1. The student is under the supervision of a
2607 licensed health care provider; and



2608 2. The student has signed an affidavit that
2609 is on file at the student's school stating that he or she has not
2610 been convicted of or pleaded guilty or nolo contendere to a felony
2611 listed in paragraph (d) of this subsection (6), or that any such
2612 conviction or plea was reversed on appeal or a pardon was granted
2613 for the conviction or plea. Before any student may sign such an
2614 affidavit, the student's school shall provide information to the
2615 student explaining what a felony is and the nature of the felonies
2616 listed in paragraph (d) of this subsection (6).

2617 However, the health care professional/vocational technical
2618 academic program in which the student is enrolled may require the
2619 student to obtain criminal history record checks. In such
2620 incidences, paragraph (a)(iii)1 and 2 of this subsection (6) does
2621 not preclude the licensing entity from processing submitted
2622 fingerprints of students from healthcare-related
2623 professional/vocational technical programs who, as part of their
2624 program of study, conduct observations and provide clinical care
2625 and services in a covered entity.

2626 (b) Under regulations promulgated by the State Board of
2627 Health, the licensing agency shall require to be performed a
2628 criminal history record check on (i) every new employee of a
2629 covered entity who provides direct patient care or services and
2630 who is employed on or after July 1, 2003, and (ii) every employee
2631 of a covered entity employed before July 1, 2003, who has a
2632 documented disciplinary action by his or her present employer. In



2633 addition, the licensing agency shall require the covered entity to
2634 perform a disciplinary check with the professional licensing
2635 agency of each employee, if any, to determine if any disciplinary
2636 action has been taken against the employee by that agency.

2637 Except as otherwise provided in paragraph (c) of this
2638 subsection (6), no such employee hired on or after July 1, 2003,
2639 shall be permitted to provide direct patient care until the
2640 results of the criminal history record check have revealed no
2641 disqualifying record or the employee has been granted a waiver.
2642 In order to determine the employee applicant's suitability for
2643 employment, the applicant shall be fingerprinted. Fingerprints
2644 shall be submitted to the licensing agency from scanning, with the
2645 results processed through the Department of Public Safety's
2646 Criminal Information Center. The fingerprints shall then be
2647 forwarded by the Department of Public Safety to the Federal Bureau
2648 of Investigation for a national criminal history record check.
2649 The licensing agency shall notify the covered entity of the
2650 results of an employee applicant's criminal history record check.
2651 If the criminal history record check discloses a felony
2652 conviction, guilty plea or plea of nolo contendere to a felony of
2653 possession or sale of drugs, murder, manslaughter, armed robbery,
2654 rape, sexual battery, sex offense listed in Section 45-33-23(h),
2655 child abuse, arson, grand larceny, burglary, gratification of lust
2656 or aggravated assault, or felonious abuse and/or battery of a
2657 vulnerable adult that has not been reversed on appeal or for which



2658 a pardon has not been granted, the employee applicant shall not be
2659 eligible to be employed by the covered entity.

2660 (c) Any such new employee applicant may, however, be
2661 employed on a temporary basis pending the results of the criminal
2662 history record check, but any employment contract with the new
2663 employee shall be voidable if the new employee receives a
2664 disqualifying criminal history record check and no waiver is
2665 granted as provided in this subsection (6).

2666 (d) Under regulations promulgated by the State Board of
2667 Health, the licensing agency shall require every employee of a
2668 covered entity employed before July 1, 2003, to sign an affidavit
2669 stating that he or she has not been convicted of or pleaded guilty
2670 or nolo contendere to a felony of possession or sale of drugs,
2671 murder, manslaughter, armed robbery, rape, sexual battery, any sex
2672 offense listed in Section 45-33-23(h), child abuse, arson, grand
2673 larceny, burglary, gratification of lust, aggravated assault, or
2674 felonious abuse and/or battery of a vulnerable adult, or that any
2675 such conviction or plea was reversed on appeal or a pardon was
2676 granted for the conviction or plea. No such employee of a covered
2677 entity hired before July 1, 2003, shall be permitted to provide
2678 direct patient care until the employee has signed the affidavit
2679 required by this paragraph (d). All such existing employees of
2680 covered entities must sign the affidavit required by this
2681 paragraph (d) within six (6) months of the final adoption of the
2682 regulations promulgated by the State Board of Health. If a person



2683 signs the affidavit required by this paragraph (d), and it is
2684 later determined that the person actually had been convicted of or
2685 pleaded guilty or nolo contendere to any of the offenses listed in
2686 this paragraph (d) and the conviction or plea has not been
2687 reversed on appeal or a pardon has not been granted for the
2688 conviction or plea, the person is guilty of perjury. If the
2689 offense that the person was convicted of or pleaded guilty or nolo
2690 contendere to was a violent offense, the person, upon a conviction
2691 of perjury under this paragraph, shall be punished as provided in
2692 Section 97-9-61. If the offense that the person was convicted of
2693 or pleaded guilty or nolo contendere to was a nonviolent offense,
2694 the person, upon a conviction of perjury under this paragraph,
2695 shall be punished by a fine of not more than Five Hundred Dollars
2696 (\$500.00), or by imprisonment in the county jail for not more than
2697 six (6) months, or by both such fine and imprisonment.

2698 (e) The covered entity may, in its discretion, allow
2699 any employee who is unable to sign the affidavit required by
2700 paragraph (d) of this subsection (6) or any employee applicant
2701 aggrieved by an employment decision under this subsection (6) to
2702 appear before the covered entity's hiring officer, or his or her
2703 designee, to show mitigating circumstances that may exist and
2704 allow the employee or employee applicant to be employed by the
2705 covered entity. The covered entity, upon report and
2706 recommendation of the hiring officer, may grant waivers for those
2707 mitigating circumstances, which shall include, but not be limited



2708 to: (i) age at which the crime was committed; (ii) circumstances
2709 surrounding the crime; (iii) length of time since the conviction
2710 and criminal history since the conviction; (iv) work history; (v)
2711 current employment and character references; and (vi) other
2712 evidence demonstrating the ability of the individual to perform
2713 the employment responsibilities competently and that the
2714 individual does not pose a threat to the health or safety of the
2715 patients of the covered entity.

2716 (f) The licensing agency may charge the covered entity
2717 submitting the fingerprints a fee not to exceed Fifty Dollars
2718 (\$50.00), which covered entity may, in its discretion, charge the
2719 same fee, or a portion thereof, to the employee applicant. Any
2720 increase in the fee charged by the licensing agency under this
2721 paragraph shall be in accordance with the provisions of Section
2722 41-3-65. Any costs incurred by a covered entity implementing this
2723 subsection (6) shall be reimbursed as an allowable cost under
2724 Section 43-13-116.

2725 (g) If the results of an employee applicant's criminal
2726 history record check reveals no disqualifying event, then the
2727 covered entity shall, within two (2) weeks of the notification of
2728 no disqualifying event, provide the employee applicant with a
2729 notarized letter signed by the chief executive officer of the
2730 covered entity, or his or her authorized designee, confirming the
2731 employee applicant's suitability for employment based on his or
2732 her criminal history record check. An employee applicant may use



2733 that letter for a period of two (2) years from the date of the
2734 letter to seek employment with any covered entity without the
2735 necessity of an additional criminal history record check. Any
2736 covered entity presented with the letter may rely on the letter
2737 with respect to an employee applicant's criminal background and is
2738 not required for a period of two (2) years from the date of the
2739 letter to conduct or have conducted a criminal history record
2740 check as required in this subsection (6).

2741 (h) The licensing agency, the covered entity, and their
2742 agents, officers, employees, attorneys and representatives, shall
2743 be presumed to be acting in good faith for any employment decision
2744 or action taken under this subsection (6). The presumption of
2745 good faith may be overcome by a preponderance of the evidence in
2746 any civil action. No licensing agency, covered entity, nor their
2747 agents, officers, employees, attorneys and representatives shall
2748 be held liable in any employment decision or action based in whole
2749 or in part on compliance with or attempts to comply with the
2750 requirements of this subsection (6).

2751 (i) The licensing agency shall promulgate regulations
2752 to implement this subsection (6).

2753 (j) The provisions of this subsection (6) shall not
2754 apply to:

2755 (i) Applicants and employees of the University of
2756 Mississippi Medical Center for whom criminal history record checks



2757 and fingerprinting are obtained in accordance with Section
2758 37-115-41; or

2759 (ii) Health care professional/vocational technical
2760 students for whom criminal history record checks and
2761 fingerprinting are obtained in accordance with Section 37-29-232.

2762 (7) The State Board of Health shall promulgate rules,
2763 regulations and standards regarding the operation of adult foster
2764 care facilities and adult day care facilities.

2765 (8) Beginning July 1, 2026, to operate an adult day care
2766 facility in Mississippi, the facility provider shall be licensed
2767 with the licensing division of the State Department of Health.
2768 Mississippi Medicaid waiver providers are required to have a state
2769 license and have a Medicaid provider contract with the Division of
2770 Medicaid. The licensure shall consist of one (1) of the following
2771 two (2) levels of service:

2772 (a) Basic Level - Level I. Facilities shall be
2773 licensed to serve clients based on the size and capacity of the
2774 facility. The facilities shall be required to provide nursing
2775 services, nutritional services, socialization and therapeutic
2776 activities. Level I facilities shall maintain, at a minimum, a
2777 staff-to-client ratio in accordance with the State Department of
2778 Health's standards. Standards governing the quality of care and
2779 services rendered shall be developed with input from all
2780 stakeholders, including the Division of Medicaid. In addition to
2781 providing adult day care services, the licensed provider is



2782 required to offer transportation services consistent with State
2783 Department of Health regulations.

2784 (b) Enhanced Level - Level II. Enhanced level
2785 facilities shall be licensed to serve clients based on the size
2786 and capacity of the facility. This type of facility may serve
2787 clients with significant impairments and medical needs as
2788 determined by the State Department of Health. The facility will
2789 be required to provide skilled nursing services in addition to
2790 nutritional services, socialization and therapeutic activities.
2791 Standards governing the quality of care and services rendered
2792 shall be developed with input from all stakeholders, including the
2793 Division of Medicaid. Enhanced level facilities shall maintain a
2794 staff-to-client ratio in accordance with the State Department of
2795 Health's standards. In addition to providing adult day care
2796 services, the license provider is required to offer transportation
2797 services consistent with State Department of Health regulations.

2798 **SECTION 8.** Section 43-13-117.1, Mississippi Code of 1972, is
2799 amended as follows:

2800 43-13-117.1. (1) It is the intent of the Legislature to
2801 expand access to Medicaid-funded home- and community-based
2802 services for eligible nursing facility residents who choose those
2803 services. The Executive Director of the Division of Medicaid is
2804 authorized to transfer funds allocated for nursing facility
2805 services for eligible residents to cover the cost of services
2806 available through the Independent Living Waiver, the Traumatic



2807 Brain Injury/Spinal Cord Injury Waiver, the Elderly and Disabled
2808 Waiver, and the Assisted Living Waiver programs when eligible
2809 residents choose those community services. The amount of funding
2810 transferred by the division shall be sufficient to cover the cost
2811 of home- and community-based waiver services for each eligible
2812 nursing facility * * *~~residents~~ resident who * * *~~choose~~ chooses
2813 those services. The number of nursing facility residents who
2814 return to the community and home- and community-based waiver
2815 services shall not count against the total number of waiver slots
2816 for which the Legislature appropriates funding each year. Any
2817 funds remaining in the program when a former nursing facility
2818 resident ceases to participate in a home- and community-based
2819 waiver program under this provision shall be returned to nursing
2820 facility funding.

2821 (2) Beginning July 1, 2026, the Division of Medicaid shall
2822 reimburse adult day care facilities based on the level of services
2823 provided by the adult day care facilities, as described in Section
2824 43-11-13.

2825 **SECTION 9.** Section 43-13-117.7, Mississippi Code of 1972, is
2826 amended as follows:

2827 43-13-117.7. (1) Notwithstanding any other provisions of
2828 Section 43-13-117, the division shall not reimburse or provide
2829 coverage for gender transition procedures for a person under
2830 eighteen (18) years of age. As used in this section, the term



2831 "gender transition procedures" means the same as defined in
2832 Section 41-141-3.

2833 (2) The division shall not reimburse or provide coverage for
2834 gender transition procedures for a person over eighteen (18) years
2835 of age.

2836 **SECTION 10.** Section 37-33-167, Mississippi Code of 1972, is
2837 amended as follows:

2838 37-33-167. The State Department of Rehabilitation Services,
2839 through the Office of Disability Determination Services, may enter
2840 into agreements with the federal Social Security Administration or
2841 its successor and other state agencies for the purpose of
2842 performing eligibility determinations for Medicaid assistance
2843 payments for those persons who qualify therefor under Section
2844 43-13-115 * * *(4), and may adopt such methods of administration
2845 as may be necessary to secure the full benefits of federal
2846 appropriations for medical assistance for such persons.

2847 **SECTION 11.** Section 43-13-145, Mississippi Code of 1972, is
2848 amended as follows:

2849 43-13-145. (1) (a) Upon each nursing facility licensed by
2850 the State of Mississippi, there is levied an assessment in an
2851 amount set by the division, equal to the maximum rate allowed by
2852 federal law or regulation, for each licensed and occupied bed of
2853 the facility.



2854 (b) A nursing facility is exempt from the assessment
2855 levied under this subsection if the facility is operated under the
2856 direction and control of:

2857 (i) The United States Veterans Administration or
2858 other agency or department of the United States government; or

2859 (ii) The State Veterans Affairs Board.

2860 (2) (a) Upon each intermediate care facility for
2861 individuals with intellectual disabilities licensed by the State
2862 of Mississippi, there is levied an assessment in an amount set by
2863 the division, equal to the maximum rate allowed by federal law or
2864 regulation, for each licensed and occupied bed of the facility.

2865 (b) An intermediate care facility for individuals with
2866 intellectual disabilities is exempt from the assessment levied
2867 under this subsection if the facility is operated under the
2868 direction and control of:

2869 (i) The United States Veterans Administration or
2870 other agency or department of the United States government;

2871 (ii) The State Veterans Affairs Board; or

2872 (iii) The University of Mississippi Medical
2873 Center.

2874 (3) (a) Upon each psychiatric residential treatment
2875 facility licensed by the State of Mississippi, there is levied an
2876 assessment in an amount set by the division, equal to the maximum
2877 rate allowed by federal law or regulation, for each licensed and
2878 occupied bed of the facility.



2879 (b) A psychiatric residential treatment facility is
2880 exempt from the assessment levied under this subsection if the
2881 facility is operated under the direction and control of:

2882 (i) The United States Veterans Administration or
2883 other agency or department of the United States government;

2884 (ii) The University of Mississippi Medical Center;
2885 or

2886 (iii) A state agency or a state facility that
2887 either provides its own state match through intergovernmental
2888 transfer or certification of funds to the division.

2889 (4) Hospital assessment.

2890 (a) (i) Subject to and upon fulfillment of the
2891 requirements and conditions of paragraph (f) below, and
2892 notwithstanding any other provisions of this section, an annual
2893 assessment on each hospital licensed in the state is imposed on
2894 each non-Medicare hospital inpatient day as defined below at a
2895 rate that is determined by dividing the sum prescribed in this
2896 subparagraph (i), plus the nonfederal share necessary to maximize
2897 the Disproportionate Share Hospital (DSH) and Medicare Upper
2898 Payment Limits (UPL) Program payments and hospital access payments
2899 and such other supplemental payments as may be developed pursuant
2900 to Section 43-13-117(A)(18), by the total number of non-Medicare
2901 hospital inpatient days as defined below for all licensed
2902 Mississippi hospitals, except as provided in paragraph (d) below.
2903 If the state-matching funds percentage for the Mississippi



2904 Medicaid program is sixteen percent (16%) or less, the sum used in
2905 the formula under this subparagraph (i) shall be Seventy-four
2906 Million Dollars (\$74,000,000.00). If the state-matching funds
2907 percentage for the Mississippi Medicaid program is twenty-four
2908 percent (24%) or higher, the sum used in the formula under this
2909 subparagraph (i) shall be One Hundred Four Million Dollars
2910 (\$104,000,000.00). If the state-matching funds percentage for the
2911 Mississippi Medicaid program is between sixteen percent (16%) and
2912 twenty-four percent (24%), the sum used in the formula under this
2913 subparagraph (i) shall be a pro rata amount determined as follows:
2914 the current state-matching funds percentage rate minus sixteen
2915 percent (16%) divided by eight percent (8%) multiplied by Thirty
2916 Million Dollars (\$30,000,000.00) and add that amount to
2917 Seventy-four Million Dollars (\$74,000,000.00). However, no
2918 assessment in a quarter under this subparagraph (i) may exceed the
2919 assessment in the previous quarter by more than Three Million
2920 Seven Hundred Fifty Thousand Dollars (\$3,750,000.00) (which would
2921 be Fifteen Million Dollars (\$15,000,000.00) on an annualized
2922 basis), unless such increase is to maximize federal funds that are
2923 available to reimburse hospitals for services provided under new
2924 programs for hospitals, for increased supplemental payment
2925 programs for hospitals or to assist with state matching funds as
2926 authorized by the Legislature. The division shall publish the
2927 state-matching funds percentage rate applicable to the Mississippi
2928 Medicaid program on the tenth day of the first month of each



2929 quarter and the assessment determined under the formula prescribed
2930 above shall be applicable in the quarter following any adjustment
2931 in that state-matching funds percentage rate. The division shall
2932 notify each hospital licensed in the state as to any projected
2933 increases or decreases in the assessment determined under this
2934 subparagraph (i). However, if the Centers for Medicare and
2935 Medicaid Services (CMS) does not approve the provision in Section
2936 43-13-117(39) requiring the division to reimburse crossover claims
2937 for inpatient hospital services and crossover claims covered under
2938 Medicare Part B for dually eligible beneficiaries in the same
2939 manner that was in effect on January 1, 2008, the sum that
2940 otherwise would have been used in the formula under this
2941 subparagraph (i) shall be reduced by Seven Million Dollars
2942 (\$7,000,000.00).

2943 (ii) In addition to the assessment provided under
2944 subparagraph (i), an additional annual assessment on each hospital
2945 licensed in the state is imposed on each non-Medicare hospital
2946 inpatient day as defined below at a rate that is determined by
2947 dividing twenty-five percent (25%) of any provider reductions in
2948 the Medicaid program as authorized in Section 43-13-117(F) for
2949 that fiscal year up to the following maximum amount, plus the
2950 nonfederal share necessary to maximize the Disproportionate Share
2951 Hospital (DSH) and inpatient Medicare Upper Payment Limits (UPL)
2952 Program payments and inpatient hospital access payments, by the
2953 total number of non-Medicare hospital inpatient days as defined



2954 below for all licensed Mississippi hospitals: in fiscal year
2955 2010, the maximum amount shall be Twenty-four Million Dollars
2956 (\$24,000,000.00); in fiscal year 2011, the maximum amount shall be
2957 Thirty-two Million Dollars (\$32,000,000.00); and in fiscal year
2958 2012 and thereafter, the maximum amount shall be Forty Million
2959 Dollars (\$40,000,000.00). Any such deficit in the Medicaid
2960 program shall be reviewed by the PEER Committee as provided in
2961 Section 43-13-117(F).

2962 (iii) In addition to the assessments provided in
2963 subparagraphs (i) and (ii), an additional annual assessment on
2964 each hospital licensed in the state is imposed pursuant to the
2965 provisions of Section 43-13-117(F) if the cost-containment
2966 measures described therein have been implemented and there are
2967 insufficient funds in the Health Care Trust Fund to reconcile any
2968 remaining deficit in any fiscal year. If the Governor institutes
2969 any other additional cost-containment measures on any program or
2970 programs authorized under the Medicaid program pursuant to Section
2971 43-13-117(F), hospitals shall be responsible for twenty-five
2972 percent (25%) of any such additional imposed provider cuts, which
2973 shall be in the form of an additional assessment not to exceed the
2974 twenty-five percent (25%) of provider expenditure reductions.
2975 Such additional assessment shall be imposed on each non-Medicare
2976 hospital inpatient day in the same manner as assessments are
2977 imposed under subparagraphs (i) and (ii).

2978 (b) Definitions.



2979 (i) [Deleted]

2980 (ii) For purposes of this subsection (4):

2981 1. "Non-Medicare hospital inpatient day"

2982 means total hospital inpatient days including subcomponent days

2983 less Medicare inpatient days including subcomponent days from the

2984 hospital's most recent Medicare cost report for the second

2985 calendar year preceding the beginning of the state fiscal year, on

2986 file with CMS per the CMS HCRIS database, or cost report submitted

2987 to the Division if the HCRIS database is not available to the

2988 division, as of June 1 of each year.

2989 a. Total hospital inpatient days shall

2990 be the sum of Worksheet S-3, Part 1, column 8 row 14, column 8 row

2991 16, and column 8 row 17, excluding column 8 rows 5 and 6.

2992 b. Hospital Medicare inpatient days

2993 shall be the sum of Worksheet S-3, Part 1, column 6 row 14, column

2994 6 row 16.00, and column 6 row 17, excluding column 6 rows 5 and 6.

2995 c. Inpatient days shall not include

2996 residential treatment or long-term care days.

2997 2. "Subcomponent inpatient day" means the

2998 number of days of care charged to a beneficiary for inpatient

2999 hospital rehabilitation and psychiatric care services in units of

3000 full days. A day begins at midnight and ends twenty-four (24)

3001 hours later. A part of a day, including the day of admission and

3002 day on which a patient returns from leave of absence, counts as a

3003 full day. However, the day of discharge, death, or a day on which



3004 a patient begins a leave of absence is not counted as a day unless
3005 discharge or death occur on the day of admission. If admission
3006 and discharge or death occur on the same day, the day is
3007 considered a day of admission and counts as one (1) subcomponent
3008 inpatient day.

3009 (c) The assessment provided in this subsection is
3010 intended to satisfy and not be in addition to the assessment and
3011 intergovernmental transfers provided in Section 43-13-117(A)(18).
3012 Nothing in this section shall be construed to authorize any state
3013 agency, division or department, or county, municipality or other
3014 local governmental unit to license for revenue, levy or impose any
3015 other tax, fee or assessment upon hospitals in this state not
3016 authorized by a specific statute.

3017 (d) Hospitals operated by the United States Department
3018 of Veterans Affairs and state-operated facilities that provide
3019 only inpatient and outpatient psychiatric services shall not be
3020 subject to the hospital assessment provided in this subsection.

3021 (e) Multihospital systems, closure, merger, change of
3022 ownership and new hospitals.

3023 (i) If a hospital conducts, operates or maintains
3024 more than one (1) hospital licensed by the State Department of
3025 Health, the provider shall pay the hospital assessment for each
3026 hospital separately.

3027 (ii) Notwithstanding any other provision in this
3028 section, if a hospital subject to this assessment operates or



3029 conducts business only for a portion of a fiscal year, the
3030 assessment for the state fiscal year shall be adjusted by
3031 multiplying the assessment by a fraction, the numerator of which
3032 is the number of days in the year during which the hospital
3033 operates, and the denominator of which is three hundred sixty-five
3034 (365). Immediately upon ceasing to operate, the hospital shall
3035 pay the assessment for the year as so adjusted (to the extent not
3036 previously paid).

3037 (iii) The division shall determine the tax for new
3038 hospitals and hospitals that undergo a change of ownership in
3039 accordance with this section, using the best available
3040 information, as determined by the division.

3041 (f) Applicability.

3042 The hospital assessment imposed by this subsection shall not
3043 take effect and/or shall cease to be imposed if:

3044 (i) The assessment is determined to be an
3045 impermissible tax under Title XIX of the Social Security Act; or

3046 (ii) CMS revokes its approval of the division's
3047 2009 Medicaid State Plan Amendment for the methodology for DSH
3048 payments to hospitals under Section 43-13-117(A)(18).

3049 (5) Each health care facility that is subject to the
3050 provisions of this section shall keep and preserve such suitable
3051 books and records as may be necessary to determine the amount of
3052 assessment for which it is liable under this section. The books
3053 and records shall be kept and preserved for a period of not less



3054 than five (5) years, during which time those books and records
3055 shall be open for examination during business hours by the
3056 division, the Department of Revenue, the Office of the Attorney
3057 General and the State Department of Health.

3058 (6) [Deleted]

3059 (7) All assessments collected under this section shall be
3060 deposited in the Medical Care Fund created by Section 43-13-143.

3061 (8) The assessment levied under this section shall be in
3062 addition to any other assessments, taxes or fees levied by law,
3063 and the assessment shall constitute a debt due the State of
3064 Mississippi from the time the assessment is due until it is paid.

3065 (9) (a) If a health care facility that is liable for
3066 payment of an assessment levied by the division does not pay the
3067 assessment when it is due, the division shall give written notice
3068 to the health care facility demanding payment of the assessment
3069 within ten (10) days from the date of delivery of the notice. If
3070 the health care facility fails or refuses to pay the assessment
3071 after receiving the notice and demand from the division, the
3072 division shall withhold from any Medicaid reimbursement payments
3073 that are due to the health care facility the amount of the unpaid
3074 assessment and a penalty of ten percent (10%) of the amount of the
3075 assessment, plus the legal rate of interest until the assessment
3076 is paid in full. If the health care facility does not participate
3077 in the Medicaid program, the division shall turn over to the
3078 Office of the Attorney General the collection of the unpaid



3079 assessment by civil action. In any such civil action, the Office
3080 of the Attorney General shall collect the amount of the unpaid
3081 assessment and a penalty of ten percent (10%) of the amount of the
3082 assessment, plus the legal rate of interest until the assessment
3083 is paid in full.

3084 (b) As an additional or alternative method for
3085 collecting unpaid assessments levied by the division, if a health
3086 care facility fails or refuses to pay the assessment after
3087 receiving notice and demand from the division, the division may
3088 file a notice of a tax lien with the chancery clerk of the county
3089 in which the health care facility is located, for the amount of
3090 the unpaid assessment and a penalty of ten percent (10%) of the
3091 amount of the assessment, plus the legal rate of interest until
3092 the assessment is paid in full. Immediately upon receipt of
3093 notice of the tax lien for the assessment, the chancery clerk
3094 shall forward the notice to the circuit clerk who shall enter the
3095 notice of the tax lien as a judgment upon the judgment roll and
3096 show in the appropriate columns the name of the health care
3097 facility as judgment debtor, the name of the division as judgment
3098 creditor, the amount of the unpaid assessment, and the date and
3099 time of enrollment. The judgment shall be valid as against
3100 mortgagees, pledgees, entrusters, purchasers, judgment creditors
3101 and other persons from the time of filing with the clerk. The
3102 amount of the judgment shall be a debt due the State of
3103 Mississippi and remain a lien upon the tangible property of the



3104 health care facility until the judgment is satisfied. The
3105 judgment shall be the equivalent of any enrolled judgment of a
3106 court of record and shall serve as authority for the issuance of
3107 writs of execution, writs of attachment or other remedial writs.

3108 (10) (a) To further the provisions of Section
3109 43-13-117(A)(18), the Division of Medicaid shall submit to the
3110 Centers for Medicare and Medicaid Services (CMS) any documents
3111 regarding the hospital assessment established under subsection (4)
3112 of this section. In addition to defining the assessment
3113 established in subsection (4) of this section if necessary, the
3114 documents shall describe any supplement payment programs and/or
3115 payment methodologies as authorized in Section 43-13-117(A)(18) if
3116 necessary.

3117 (b) All hospitals satisfying the minimum federal DSH
3118 eligibility requirements (Section 1923(d) of the Social Security
3119 Act) may, subject to OBRA 1993 payment limitations, receive a DSH
3120 payment. This DSH payment shall expend the balance of the federal
3121 DSH allotment and associated state share not utilized in DSH
3122 payments to state-owned institutions for treatment of mental
3123 diseases. The payment to each hospital shall be calculated by
3124 applying a uniform percentage to the uninsured costs of each
3125 eligible hospital, excluding state-owned institutions for
3126 treatment of mental diseases; however, that percentage for a
3127 state-owned teaching hospital located in Hinds County shall be
3128 multiplied by a factor of two (2).



3129 (11) The division shall implement DSH and supplemental
3130 payment calculation methodologies that result in the maximization
3131 of available federal funds.

3132 (12) The DSH payments shall be paid on or before December
3133 31, March 31, and June 30 of each fiscal year, in increments of
3134 one-third (1/3) of the total calculated DSH amounts. Supplemental
3135 payments developed pursuant to Section 43-13-117(A)(18) shall be
3136 paid monthly.

3137 (13) Payment.

3138 (a) The hospital assessment as described in subsection
3139 (4) for the nonfederal share necessary to maximize the Medicare
3140 Upper Payments Limits (UPL) Program payments and hospital access
3141 payments and such other supplemental payments as may be developed
3142 pursuant to Section 43-3-117(A)(18) shall be assessed and
3143 collected monthly no later than the fifteenth calendar day of each
3144 month.

3145 (b) The hospital assessment as described in subsection
3146 (4) for the nonfederal share necessary to maximize the
3147 Disproportionate Share Hospital (DSH) payments shall be assessed
3148 and collected on December 15, March 15 and June 15.

3149 (c) The annual hospital assessment and any additional
3150 hospital assessment as described in subsection (4) shall be
3151 assessed and collected on September 15 and on the 15th of each
3152 month from December through June.



3153 (14) If for any reason any part of the plan for annual DSH
3154 and supplemental payment programs to hospitals provided under
3155 subsection (10) of this section and/or developed pursuant to
3156 Section 43-13-117(A) (18) is not approved by CMS, the remainder of
3157 the plan shall remain in full force and effect.

3158 (15) Nothing in this section shall prevent the Division of
3159 Medicaid from facilitating participation in Medicaid supplemental
3160 hospital payment programs by a hospital located in a county
3161 contiguous to the State of Mississippi that is also authorized by
3162 federal law to submit intergovernmental transfers (IGTs) to the
3163 State of Mississippi to fund the state share of the hospital's
3164 supplemental and/or MHAP payments.

3165 (16) This section shall stand repealed on July 1, 2028.

3166 **SECTION 12.** Section 43-13-115.1, Mississippi Code of 1972,
3167 is amended as follows:

3168 43-13-115.1. (1) Ambulatory prenatal care shall be
3169 available to a pregnant woman under this article during a
3170 presumptive eligibility period in accordance with the provisions
3171 of this section.

3172 (2) For purposes of this section, the following terms shall
3173 be defined as provided in this subsection:

3174 (a) "Presumptive eligibility" means a reasonable
3175 determination of Medicaid eligibility of a pregnant woman made by
3176 a qualified provider based only on the countable family income of
3177 the woman, which allows the woman to receive ambulatory prenatal



3178 care under this article during a presumptive eligibility period
3179 while the Division of Medicaid makes a determination with respect
3180 to the eligibility of the woman for Medicaid.

3181 (b) "Presumptive eligibility period" means, with
3182 respect to a pregnant woman, the period that:

3183 (i) Begins with the date on which a qualified
3184 provider determines, on the basis of preliminary information, that
3185 the total countable net family income of the woman does not exceed
3186 the income limits for eligibility of pregnant women in the
3187 Medicaid state plan; and

3188 (ii) Ends with, and includes, the earlier of:

3189 1. The day on which a determination is made
3190 with respect to the eligibility of the woman for Medicaid;

3191 2. In the case of a woman who does not file
3192 an application by the last day of the month following the month
3193 during which the provider makes the determination referred to in
3194 subparagraph (i) of this paragraph, such last day; or

3195 3. Sixty (60) days after the day that the
3196 provider makes the determination referred to in subparagraph (i)
3197 of this paragraph.

3198 (c) "Qualified provider" means any provider that meets
3199 the definition of "qualified provider" under 42 USC Section
3200 1396r-1. The term includes, but is not limited to, county health
3201 departments, federally qualified health centers (FQHCs), and other



3202 entities approved and designated by the Division of Medicaid to
3203 conduct presumptive eligibility determinations for pregnant women.

3204 (3) A pregnant woman shall be deemed to be presumptively
3205 eligible for ambulatory prenatal care under this article if a
3206 qualified provider determines, on the basis of preliminary
3207 information, that the total countable net family income of the
3208 woman does not exceed the income limits for eligibility of
3209 pregnant women in the Medicaid state plan. * * * ~~A pregnant woman
3210 must, at a minimum, provide proof of her pregnancy and
3211 documentation of her monthly family income when seeking a
3212 determination of presumptive eligibility.~~ A pregnant woman who is
3213 determined to be presumptively eligible may receive no more than
3214 one (1) presumptive eligibility period per pregnancy.

3215 (4) A qualified provider that determines that a pregnant
3216 woman is presumptively eligible for Medicaid shall:

3217 (a) Notify the Division of Medicaid of the
3218 determination within five (5) working days after the date on which
3219 determination is made; and

3220 (b) Inform the woman at the time the determination is
3221 made that she is required to make application for Medicaid by not
3222 later than the last day of the month following the month during
3223 which the determination is made.

3224 (5) A pregnant woman who is determined by a qualified
3225 provider to be presumptively eligible for Medicaid shall make



3226 application for Medicaid by not later than the last day of the
3227 month following the month during which the determination is made.

3228 (6) The Division of Medicaid shall provide qualified
3229 providers with such forms as are necessary for a pregnant woman to
3230 make application for Medicaid and information on how to assist
3231 such women in completing and filing such forms. The division
3232 shall make those application forms and the application process
3233 itself as simple as possible.

3234 **SECTION 13.** Section 41-7-191, Mississippi Code of 1972, is
3235 amended as follows:

3236 41-7-191. (1) No person shall engage in any of the
3237 following activities without obtaining the required certificate of
3238 need:

3239 (a) The construction, development or other
3240 establishment of a new health care facility, which establishment
3241 shall include the reopening of a health care facility that has
3242 ceased to operate for a period of sixty (60) months or more;

3243 (b) The relocation of a health care facility or portion
3244 thereof, or major medical equipment, unless such relocation of a
3245 health care facility or portion thereof, or major medical
3246 equipment, which does not involve a capital expenditure by or on
3247 behalf of a health care facility, is within five thousand two
3248 hundred eighty (5,280) feet from the main entrance of the health
3249 care facility;



3250 (c) Any change in the existing bed complement of any
3251 health care facility through the addition or conversion of any
3252 beds or the alteration, modernizing or refurbishing of any unit or
3253 department in which the beds may be located; however, if a health
3254 care facility has voluntarily delicensed some of its existing bed
3255 complement, it may later relicense some or all of its delicensed
3256 beds without the necessity of having to acquire a certificate of
3257 need. The State Department of Health shall maintain a record of
3258 the delicensing health care facility and its voluntarily
3259 delicensed beds and continue counting those beds as part of the
3260 state's total bed count for health care planning purposes. If a
3261 health care facility that has voluntarily delicensed some of its
3262 beds later desires to relicense some or all of its voluntarily
3263 delicensed beds, it shall notify the State Department of Health of
3264 its intent to increase the number of its licensed beds. The State
3265 Department of Health shall survey the health care facility within
3266 thirty (30) days of that notice and, if appropriate, issue the
3267 health care facility a new license reflecting the new contingent
3268 of beds. However, in no event may a health care facility that has
3269 voluntarily delicensed some of its beds be reissued a license to
3270 operate beds in excess of its bed count before the voluntary
3271 delicensure of some of its beds without seeking certificate of
3272 need approval;

3273 (d) Offering of the following health services if those
3274 services have not been provided on a regular basis by the proposed



3275 provider of such services within the period of twelve (12) months
3276 prior to the time such services would be offered:

3277 (i) Open-heart surgery services;
3278 (ii) Cardiac catheterization services;
3279 (iii) Comprehensive inpatient rehabilitation

3280 services;

3281 (iv) Licensed psychiatric services;

3282 (v) Licensed chemical dependency services;

3283 (vi) Radiation therapy services;

3284 (vii) Diagnostic imaging services of an invasive
3285 nature, i.e. invasive digital angiography;

3286 (viii) Nursing home care as defined in
3287 subparagraphs (iv), (vi) and (viii) of Section 41-7-173(h);

3288 (ix) Home health services;

3289 (x) Swing-bed services;

3290 (xi) Ambulatory surgical services;

3291 (xii) Magnetic resonance imaging services;

3292 (xiii) [Deleted]

3293 (xiv) Long-term care hospital services;

3294 (xv) Positron emission tomography (PET) services;

3295 (e) The relocation of one or more health services from
3296 one physical facility or site to another physical facility or
3297 site, unless such relocation, which does not involve a capital
3298 expenditure by or on behalf of a health care facility, (i) is to a
3299 physical facility or site within five thousand two hundred eighty



3300 (5,280) feet from the main entrance of the health care facility
3301 where the health care service is located, or (ii) is the result of
3302 an order of a court of appropriate jurisdiction or a result of
3303 pending litigation in such court, or by order of the State
3304 Department of Health, or by order of any other agency or legal
3305 entity of the state, the federal government, or any political
3306 subdivision of either, whose order is also approved by the State
3307 Department of Health;

3308 (f) The acquisition or otherwise control of any major
3309 medical equipment for the provision of medical services; however,
3310 (i) the acquisition of any major medical equipment used only for
3311 research purposes, and (ii) the acquisition of major medical
3312 equipment to replace medical equipment for which a facility is
3313 already providing medical services and for which the State
3314 Department of Health has been notified before the date of such
3315 acquisition shall be exempt from this paragraph; an acquisition
3316 for less than fair market value must be reviewed, if the
3317 acquisition at fair market value would be subject to review;

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



3324 than fair market value must be reviewed, if the acquisition at
3325 fair market value would be subject to review;

3326 (h) The change of ownership of any health care facility
3327 defined in subparagraphs (iv), (vi) and (viii) of Section
3328 41-7-173(h), in which a notice of intent as described in paragraph
3329 (g) has not been filed and if the Executive Director, Division of
3330 Medicaid, Office of the Governor, has not certified in writing
3331 that there will be no increase in allowable costs to Medicaid from
3332 revaluation of the assets or from increased interest and
3333 depreciation as a result of the proposed change of ownership;

3334 (i) Any activity described in paragraphs (a) through
3335 (h) if undertaken by any person if that same activity would
3336 require certificate of need approval if undertaken by a health
3337 care facility;

3338 (j) Any capital expenditure or deferred capital
3339 expenditure by or on behalf of a health care facility not covered
3340 by paragraphs (a) through (h);

3341 (k) The contracting of a health care facility as
3342 defined in subparagraphs (i) through (viii) of Section 41-7-173(h)
3343 to establish a home office, subunit, or branch office in the space
3344 operated as a health care facility through a formal arrangement
3345 with an existing health care facility as defined in subparagraph
3346 (ix) of Section 41-7-173(h);

3347 (l) The replacement or relocation of a health care
3348 facility designated as a critical access hospital shall be exempt



3349 from subsection (1) of this section so long as the critical access
3350 hospital complies with all applicable federal law and regulations
3351 regarding such replacement or relocation;

3352 (m) Reopening a health care facility that has ceased to
3353 operate for a period of sixty (60) months or more, which reopening
3354 requires a certificate of need for the establishment of a new
3355 health care facility.

3356 (2) The State Department of Health shall not grant approval
3357 for or issue a certificate of need to any person proposing the new
3358 construction of, addition to, or expansion of any health care
3359 facility defined in subparagraphs (iv) (skilled nursing facility)
3360 and (vi) (intermediate care facility) of Section 41-7-173(h) or
3361 the conversion of vacant hospital beds to provide skilled or
3362 intermediate nursing home care, except as hereinafter authorized:

3363 (a) The department may issue a certificate of need to
3364 any person proposing the new construction of any health care
3365 facility defined in subparagraphs (iv) and (vi) of Section
3366 41-7-173(h) as part of a life care retirement facility, in any
3367 county bordering on the Gulf of Mexico in which is located a
3368 National Aeronautics and Space Administration facility, not to
3369 exceed forty (40) beds. From and after July 1, 1999, there shall
3370 be no prohibition or restrictions on participation in the Medicaid
3371 program (Section 43-13-101 et seq.) for the beds in the health
3372 care facility that were authorized under this paragraph (a).



3373 (b) The department may issue certificates of need in
3374 Harrison County to provide skilled nursing home care for
3375 Alzheimer's disease patients and other patients, not to exceed one
3376 hundred fifty (150) beds. From and after July 1, 1999, there
3377 shall be no prohibition or restrictions on participation in the
3378 Medicaid program (Section 43-13-101 et seq.) for the beds in the
3379 nursing facilities that were authorized under this paragraph (b).

3380 (c) The department may issue a certificate of need for
3381 the addition to or expansion of any skilled nursing facility that
3382 is part of an existing continuing care retirement community
3383 located in Madison County, provided that the recipient of the
3384 certificate of need agrees in writing that the skilled nursing
3385 facility will not at any time participate in the Medicaid program
3386 (Section 43-13-101 et seq.) or admit or keep any patients in the
3387 skilled nursing facility who are participating in the Medicaid
3388 program. This written agreement by the recipient of the
3389 certificate of need shall be fully binding on any subsequent owner
3390 of the skilled nursing facility, if the ownership of the facility
3391 is transferred at any time after the issuance of the certificate
3392 of need. Agreement that the skilled nursing facility will not
3393 participate in the Medicaid program shall be a condition of the
3394 issuance of a certificate of need to any person under this
3395 paragraph (c), and if such skilled nursing facility at any time
3396 after the issuance of the certificate of need, regardless of the
3397 ownership of the facility, participates in the Medicaid program or



3398 admits or keeps any patients in the facility who are participating
3399 in the Medicaid program, the State Department of Health shall
3400 revoke the certificate of need, if it is still outstanding, and
3401 shall deny or revoke the license of the skilled nursing facility,
3402 at the time that the department determines, after a hearing
3403 complying with due process, that the facility has failed to comply
3404 with any of the conditions upon which the certificate of need was
3405 issued, as provided in this paragraph and in the written agreement
3406 by the recipient of the certificate of need. The total number of
3407 beds that may be authorized under the authority of this paragraph
3408 (c) shall not exceed sixty (60) beds.

3409 (d) The State Department of Health may issue a
3410 certificate of need to any hospital located in DeSoto County for
3411 the new construction of a skilled nursing facility, not to exceed
3412 one hundred twenty (120) beds, in DeSoto County. From and after
3413 July 1, 1999, there shall be no prohibition or restrictions on
3414 participation in the Medicaid program (Section 43-13-101 et seq.)
3415 for the beds in the nursing facility that were authorized under
3416 this paragraph (d).

3417 (e) The State Department of Health may issue a
3418 certificate of need for the construction of a nursing facility or
3419 the conversion of beds to nursing facility beds at a personal care
3420 facility for the elderly in Lowndes County that is owned and
3421 operated by a Mississippi nonprofit corporation, not to exceed
3422 sixty (60) beds. From and after July 1, 1999, there shall be no



3423 prohibition or restrictions on participation in the Medicaid
3424 program (Section 43-13-101 et seq.) for the beds in the nursing
3425 facility that were authorized under this paragraph (e).

3426 (f) The State Department of Health may issue a
3427 certificate of need for conversion of a county hospital facility
3428 in Itawamba County to a nursing facility, not to exceed sixty (60)
3429 beds, including any necessary construction, renovation or
3430 expansion. From and after July 1, 1999, there shall be no
3431 prohibition or restrictions on participation in the Medicaid
3432 program (Section 43-13-101 et seq.) for the beds in the nursing
3433 facility that were authorized under this paragraph (f).

3434 (g) The State Department of Health may issue a
3435 certificate of need for the construction or expansion of nursing
3436 facility beds or the conversion of other beds to nursing facility
3437 beds in either Hinds, Madison or Rankin County, not to exceed
3438 sixty (60) beds. From and after July 1, 1999, there shall be no
3439 prohibition or restrictions on participation in the Medicaid
3440 program (Section 43-13-101 et seq.) for the beds in the nursing
3441 facility that were authorized under this paragraph (g).

3442 (h) The State Department of Health may issue a
3443 certificate of need for the construction or expansion of nursing
3444 facility beds or the conversion of other beds to nursing facility
3445 beds in either Hancock, Harrison or Jackson County, not to exceed
3446 sixty (60) beds. From and after July 1, 1999, there shall be no
3447 prohibition or restrictions on participation in the Medicaid



3448 program (Section 43-13-101 et seq.) for the beds in the facility
3449 that were authorized under this paragraph (h).

3450 (i) The department may issue a certificate of need for
3451 the new construction of a skilled nursing facility in Leake
3452 County, provided that the recipient of the certificate of need
3453 agrees in writing that the skilled nursing facility will not at
3454 any time participate in the Medicaid program (Section 43-13-101 et
3455 seq.) or admit or keep any patients in the skilled nursing
3456 facility who are participating in the Medicaid program. This
3457 written agreement by the recipient of the certificate of need
3458 shall be fully binding on any subsequent owner of the skilled
3459 nursing facility, if the ownership of the facility is transferred
3460 at any time after the issuance of the certificate of need.
3461 Agreement that the skilled nursing facility will not participate
3462 in the Medicaid program shall be a condition of the issuance of a
3463 certificate of need to any person under this paragraph (i), and if
3464 such skilled nursing facility at any time after the issuance of
3465 the certificate of need, regardless of the ownership of the
3466 facility, participates in the Medicaid program or admits or keeps
3467 any patients in the facility who are participating in the Medicaid
3468 program, the State Department of Health shall revoke the
3469 certificate of need, if it is still outstanding, and shall deny or
3470 revoke the license of the skilled nursing facility, at the time
3471 that the department determines, after a hearing complying with due
3472 process, that the facility has failed to comply with any of the



3473 conditions upon which the certificate of need was issued, as
3474 provided in this paragraph and in the written agreement by the
3475 recipient of the certificate of need. The provision of Section
3476 41-7-193(1) regarding substantial compliance of the projection of
3477 need as reported in the current State Health Plan is waived for
3478 the purposes of this paragraph. The total number of nursing
3479 facility beds that may be authorized by any certificate of need
3480 issued under this paragraph (i) shall not exceed sixty (60) beds.
3481 If the skilled nursing facility authorized by the certificate of
3482 need issued under this paragraph is not constructed and fully
3483 operational within eighteen (18) months after July 1, 1994, the
3484 State Department of Health, after a hearing complying with due
3485 process, shall revoke the certificate of need, if it is still
3486 outstanding, and shall not issue a license for the skilled nursing
3487 facility at any time after the expiration of the eighteen-month
3488 period.

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



3498 seq.) for the beds in the long-term care facilities that were
3499 authorized under this paragraph (j).

3500 (k) The department may issue a certificate of need for
3501 the construction of a nursing facility at a continuing care
3502 retirement community in Lowndes County. The total number of beds
3503 that may be authorized under the authority of this paragraph (k)
3504 shall not exceed sixty (60) beds. From and after July 1, 2001,
3505 the prohibition on the facility participating in the Medicaid
3506 program (Section 43-13-101 et seq.) that was a condition of
3507 issuance of the certificate of need under this paragraph (k) shall
3508 be revised as follows: The nursing facility may participate in
3509 the Medicaid program from and after July 1, 2001, if the owner of
3510 the facility on July 1, 2001, agrees in writing that no more than
3511 thirty (30) of the beds at the facility will be certified for
3512 participation in the Medicaid program, and that no claim will be
3513 submitted for Medicaid reimbursement for more than thirty (30)
3514 patients in the facility in any month or for any patient in the
3515 facility who is in a bed that is not Medicaid-certified. This
3516 written agreement by the owner of the facility shall be a
3517 condition of licensure of the facility, and the agreement shall be
3518 fully binding on any subsequent owner of the facility if the
3519 ownership of the facility is transferred at any time after July 1,
3520 2001. After this written agreement is executed, the Division of
3521 Medicaid and the State Department of Health shall not certify more
3522 than thirty (30) of the beds in the facility for participation in



3523 the Medicaid program. If the facility violates the terms of the
3524 written agreement by admitting or keeping in the facility on a
3525 regular or continuing basis more than thirty (30) patients who are
3526 participating in the Medicaid program, the State Department of
3527 Health shall revoke the license of the facility, at the time that
3528 the department determines, after a hearing complying with due
3529 process, that the facility has violated the written agreement.

3530 (l) Provided that funds are specifically appropriated
3531 therefor by the Legislature, the department may issue a
3532 certificate of need to a rehabilitation hospital in Hinds County
3533 for the construction of a sixty-bed long-term care nursing
3534 facility dedicated to the care and treatment of persons with
3535 severe disabilities including persons with spinal cord and
3536 closed-head injuries and ventilator dependent patients. The
3537 provisions of Section 41-7-193(1) regarding substantial compliance
3538 with projection of need as reported in the current State Health
3539 Plan are waived for the purpose of this paragraph.

3540 (m) The State Department of Health may issue a
3541 certificate of need to a county-owned hospital in the Second
3542 Judicial District of Panola County for the conversion of not more
3543 than seventy-two (72) hospital beds to nursing facility beds,
3544 provided that the recipient of the certificate of need agrees in
3545 writing that none of the beds at the nursing facility will be
3546 certified for participation in the Medicaid program (Section
3547 43-13-101 et seq.), and that no claim will be submitted for



3548 Medicaid reimbursement in the nursing facility in any day or for
3549 any patient in the nursing facility. This written agreement by
3550 the recipient of the certificate of need shall be a condition of
3551 the issuance of the certificate of need under this paragraph, and
3552 the agreement shall be fully binding on any subsequent owner of
3553 the nursing facility if the ownership of the nursing facility is
3554 transferred at any time after the issuance of the certificate of
3555 need. After this written agreement is executed, the Division of
3556 Medicaid and the State Department of Health shall not certify any
3557 of the beds in the nursing facility for participation in the
3558 Medicaid program. If the nursing facility violates the terms of
3559 the written agreement by admitting or keeping in the nursing
3560 facility on a regular or continuing basis any patients who are
3561 participating in the Medicaid program, the State Department of
3562 Health shall revoke the license of the nursing facility, at the
3563 time that the department determines, after a hearing complying
3564 with due process, that the nursing facility has violated the
3565 condition upon which the certificate of need was issued, as
3566 provided in this paragraph and in the written agreement. If the
3567 certificate of need authorized under this paragraph is not issued
3568 within twelve (12) months after July 1, 2001, the department shall
3569 deny the application for the certificate of need and shall not
3570 issue the certificate of need at any time after the twelve-month
3571 period, unless the issuance is contested. If the certificate of
3572 need is issued and substantial construction of the nursing



3573 facility beds has not commenced within eighteen (18) months after
3574 July 1, 2001, the State Department of Health, after a hearing
3575 complying with due process, shall revoke the certificate of need
3576 if it is still outstanding, and the department shall not issue a
3577 license for the nursing facility at any time after the
3578 eighteen-month period. However, if the issuance of the
3579 certificate of need is contested, the department shall require
3580 substantial construction of the nursing facility beds within six
3581 (6) months after final adjudication on the issuance of the
3582 certificate of need.

3583 (n) The department may issue a certificate of need for
3584 the new construction, addition or conversion of skilled nursing
3585 facility beds in Madison County, provided that the recipient of
3586 the certificate of need agrees in writing that the skilled nursing
3587 facility will not at any time participate in the Medicaid program
3588 (Section 43-13-101 et seq.) or admit or keep any patients in the
3589 skilled nursing facility who are participating in the Medicaid
3590 program. This written agreement by the recipient of the
3591 certificate of need shall be fully binding on any subsequent owner
3592 of the skilled nursing facility, if the ownership of the facility
3593 is transferred at any time after the issuance of the certificate
3594 of need. Agreement that the skilled nursing facility will not
3595 participate in the Medicaid program shall be a condition of the
3596 issuance of a certificate of need to any person under this
3597 paragraph (n), and if such skilled nursing facility at any time



3598 after the issuance of the certificate of need, regardless of the
3599 ownership of the facility, participates in the Medicaid program or
3600 admits or keeps any patients in the facility who are participating
3601 in the Medicaid program, the State Department of Health shall
3602 revoke the certificate of need, if it is still outstanding, and
3603 shall deny or revoke the license of the skilled nursing facility,
3604 at the time that the department determines, after a hearing
3605 complying with due process, that the facility has failed to comply
3606 with any of the conditions upon which the certificate of need was
3607 issued, as provided in this paragraph and in the written agreement
3608 by the recipient of the certificate of need. The total number of
3609 nursing facility beds that may be authorized by any certificate of
3610 need issued under this paragraph (n) shall not exceed sixty (60)
3611 beds. If the certificate of need authorized under this paragraph
3612 is not issued within twelve (12) months after July 1, 1998, the
3613 department shall deny the application for the certificate of need
3614 and shall not issue the certificate of need at any time after the
3615 twelve-month period, unless the issuance is contested. If the
3616 certificate of need is issued and substantial construction of the
3617 nursing facility beds has not commenced within eighteen (18)
3618 months after July 1, 1998, the State Department of Health, after a
3619 hearing complying with due process, shall revoke the certificate
3620 of need if it is still outstanding, and the department shall not
3621 issue a license for the nursing facility at any time after the
3622 eighteen-month period. However, if the issuance of the



3623 certificate of need is contested, the department shall require
3624 substantial construction of the nursing facility beds within six
3625 (6) months after final adjudication on the issuance of the
3626 certificate of need.

3627 (o) The department may issue a certificate of need for
3628 the new construction, addition or conversion of skilled nursing
3629 facility beds in Leake County, provided that the recipient of the
3630 certificate of need agrees in writing that the skilled nursing
3631 facility will not at any time participate in the Medicaid program
3632 (Section 43-13-101 et seq.) or admit or keep any patients in the
3633 skilled nursing facility who are participating in the Medicaid
3634 program. This written agreement by the recipient of the
3635 certificate of need shall be fully binding on any subsequent owner
3636 of the skilled nursing facility, if the ownership of the facility
3637 is transferred at any time after the issuance of the certificate
3638 of need. Agreement that the skilled nursing facility will not
3639 participate in the Medicaid program shall be a condition of the
3640 issuance of a certificate of need to any person under this
3641 paragraph (o), and if such skilled nursing facility at any time
3642 after the issuance of the certificate of need, regardless of the
3643 ownership of the facility, participates in the Medicaid program or
3644 admits or keeps any patients in the facility who are participating
3645 in the Medicaid program, the State Department of Health shall
3646 revoke the certificate of need, if it is still outstanding, and
3647 shall deny or revoke the license of the skilled nursing facility,



3648 at the time that the department determines, after a hearing
3649 complying with due process, that the facility has failed to comply
3650 with any of the conditions upon which the certificate of need was
3651 issued, as provided in this paragraph and in the written agreement
3652 by the recipient of the certificate of need. The total number of
3653 nursing facility beds that may be authorized by any certificate of
3654 need issued under this paragraph (o) shall not exceed sixty (60)
3655 beds. If the certificate of need authorized under this paragraph
3656 is not issued within twelve (12) months after July 1, 2001, the
3657 department shall deny the application for the certificate of need
3658 and shall not issue the certificate of need at any time after the
3659 twelve-month period, unless the issuance is contested. If the
3660 certificate of need is issued and substantial construction of the
3661 nursing facility beds has not commenced within eighteen (18)
3662 months after July 1, 2001, the State Department of Health, after a
3663 hearing complying with due process, shall revoke the certificate
3664 of need if it is still outstanding, and the department shall not
3665 issue a license for the nursing facility at any time after the
3666 eighteen-month period. However, if the issuance of the
3667 certificate of need is contested, the department shall require
3668 substantial construction of the nursing facility beds within six
3669 (6) months after final adjudication on the issuance of the
3670 certificate of need.

3671 (p) The department may issue a certificate of need for
3672 the construction of a municipally owned nursing facility within



3673 the Town of Belmont in Tishomingo County, not to exceed sixty (60)
3674 beds, provided that the recipient of the certificate of need
3675 agrees in writing that the skilled nursing facility will not at
3676 any time participate in the Medicaid program (Section 43-13-101 et
3677 seq.) or admit or keep any patients in the skilled nursing
3678 facility who are participating in the Medicaid program. This
3679 written agreement by the recipient of the certificate of need
3680 shall be fully binding on any subsequent owner of the skilled
3681 nursing facility, if the ownership of the facility is transferred
3682 at any time after the issuance of the certificate of need.
3683 Agreement that the skilled nursing facility will not participate
3684 in the Medicaid program shall be a condition of the issuance of a
3685 certificate of need to any person under this paragraph (p), and if
3686 such skilled nursing facility at any time after the issuance of
3687 the certificate of need, regardless of the ownership of the
3688 facility, participates in the Medicaid program or admits or keeps
3689 any patients in the facility who are participating in the Medicaid
3690 program, the State Department of Health shall revoke the
3691 certificate of need, if it is still outstanding, and shall deny or
3692 revoke the license of the skilled nursing facility, at the time
3693 that the department determines, after a hearing complying with due
3694 process, that the facility has failed to comply with any of the
3695 conditions upon which the certificate of need was issued, as
3696 provided in this paragraph and in the written agreement by the
3697 recipient of the certificate of need. The provision of Section



3698 41-7-193(1) regarding substantial compliance of the projection of
3699 need as reported in the current State Health Plan is waived for
3700 the purposes of this paragraph. If the certificate of need
3701 authorized under this paragraph is not issued within twelve (12)
3702 months after July 1, 1998, the department shall deny the
3703 application for the certificate of need and shall not issue the
3704 certificate of need at any time after the twelve-month period,
3705 unless the issuance is contested. If the certificate of need is
3706 issued and substantial construction of the nursing facility beds
3707 has not commenced within eighteen (18) months after July 1, 1998,
3708 the State Department of Health, after a hearing complying with due
3709 process, shall revoke the certificate of need if it is still
3710 outstanding, and the department shall not issue a license for the
3711 nursing facility at any time after the eighteen-month period.
3712 However, if the issuance of the certificate of need is contested,
3713 the department shall require substantial construction of the
3714 nursing facility beds within six (6) months after final
3715 adjudication on the issuance of the certificate of need.

3716 (q) (i) Beginning on July 1, 1999, the State
3717 Department of Health shall issue certificates of need during each
3718 of the next four (4) fiscal years for the construction or
3719 expansion of nursing facility beds or the conversion of other beds
3720 to nursing facility beds in each county in the state having a need
3721 for fifty (50) or more additional nursing facility beds, as shown
3722 in the fiscal year 1999 State Health Plan, in the manner provided



3723 in this paragraph (q). The total number of nursing facility beds
3724 that may be authorized by any certificate of need authorized under
3725 this paragraph (q) shall not exceed sixty (60) beds.

3726 (ii) Subject to the provisions of subparagraph
3727 (v), during each of the next four (4) fiscal years, the department
3728 shall issue six (6) certificates of need for new nursing facility
3729 beds, as follows: During fiscal years 2000, 2001 and 2002, one
3730 (1) certificate of need shall be issued for new nursing facility
3731 beds in the county in each of the four (4) Long-Term Care Planning
3732 Districts designated in the fiscal year 1999 State Health Plan
3733 that has the highest need in the district for those beds; and two
3734 (2) certificates of need shall be issued for new nursing facility
3735 beds in the two (2) counties from the state at large that have the
3736 highest need in the state for those beds, when considering the
3737 need on a statewide basis and without regard to the Long-Term Care
3738 Planning Districts in which the counties are located. During
3739 fiscal year 2003, one (1) certificate of need shall be issued for
3740 new nursing facility beds in any county having a need for fifty
3741 (50) or more additional nursing facility beds, as shown in the
3742 fiscal year 1999 State Health Plan, that has not received a
3743 certificate of need under this paragraph (q) during the three (3)
3744 previous fiscal years. During fiscal year 2000, in addition to
3745 the six (6) certificates of need authorized in this subparagraph,
3746 the department also shall issue a certificate of need for new



3747 nursing facility beds in Amite County and a certificate of need
3748 for new nursing facility beds in Carroll County.

3749 (iii) Subject to the provisions of subparagraph
3750 (v), the certificate of need issued under subparagraph (ii) for
3751 nursing facility beds in each Long-Term Care Planning District
3752 during each fiscal year shall first be available for nursing
3753 facility beds in the county in the district having the highest
3754 need for those beds, as shown in the fiscal year 1999 State Health
3755 Plan. If there are no applications for a certificate of need for
3756 nursing facility beds in the county having the highest need for
3757 those beds by the date specified by the department, then the
3758 certificate of need shall be available for nursing facility beds
3759 in other counties in the district in descending order of the need
3760 for those beds, from the county with the second highest need to
3761 the county with the lowest need, until an application is received
3762 for nursing facility beds in an eligible county in the district.

3763 (iv) Subject to the provisions of subparagraph
3764 (v), the certificate of need issued under subparagraph (ii) for
3765 nursing facility beds in the two (2) counties from the state at
3766 large during each fiscal year shall first be available for nursing
3767 facility beds in the two (2) counties that have the highest need
3768 in the state for those beds, as shown in the fiscal year 1999
3769 State Health Plan, when considering the need on a statewide basis
3770 and without regard to the Long-Term Care Planning Districts in
3771 which the counties are located. If there are no applications for



3772 a certificate of need for nursing facility beds in either of the
3773 two (2) counties having the highest need for those beds on a
3774 statewide basis by the date specified by the department, then the
3775 certificate of need shall be available for nursing facility beds
3776 in other counties from the state at large in descending order of
3777 the need for those beds on a statewide basis, from the county with
3778 the second highest need to the county with the lowest need, until
3779 an application is received for nursing facility beds in an
3780 eligible county from the state at large.

3781 (v) If a certificate of need is authorized to be
3782 issued under this paragraph (q) for nursing facility beds in a
3783 county on the basis of the need in the Long-Term Care Planning
3784 District during any fiscal year of the four-year period, a
3785 certificate of need shall not also be available under this
3786 paragraph (q) for additional nursing facility beds in that county
3787 on the basis of the need in the state at large, and that county
3788 shall be excluded in determining which counties have the highest
3789 need for nursing facility beds in the state at large for that
3790 fiscal year. After a certificate of need has been issued under
3791 this paragraph (q) for nursing facility beds in a county during
3792 any fiscal year of the four-year period, a certificate of need
3793 shall not be available again under this paragraph (q) for
3794 additional nursing facility beds in that county during the
3795 four-year period, and that county shall be excluded in determining



3796 which counties have the highest need for nursing facility beds in
3797 succeeding fiscal years.

3798 (vi) If more than one (1) application is made for
3799 a certificate of need for nursing home facility beds available
3800 under this paragraph (q), in Yalobusha, Newton or Tallahatchie
3801 County, and one (1) of the applicants is a county-owned hospital
3802 located in the county where the nursing facility beds are
3803 available, the department shall give priority to the county-owned
3804 hospital in granting the certificate of need if the following
3805 conditions are met:

3806 1. The county-owned hospital fully meets all
3807 applicable criteria and standards required to obtain a certificate
3808 of need for the nursing facility beds; and

3809 2. The county-owned hospital's qualifications
3810 for the certificate of need, as shown in its application and as
3811 determined by the department, are at least equal to the
3812 qualifications of the other applicants for the certificate of
3813 need.

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



3820 Plan, to provide care exclusively to patients with Alzheimer's
3821 disease.

3822 (ii) Not more than twenty (20) beds may be
3823 authorized by any certificate of need issued under this paragraph
3824 (r), and not more than a total of sixty (60) beds may be
3825 authorized in any Long-Term Care Planning District by all
3826 certificates of need issued under this paragraph (r). However,
3827 the total number of beds that may be authorized by all
3828 certificates of need issued under this paragraph (r) during any
3829 fiscal year shall not exceed one hundred twenty (120) beds, and
3830 the total number of beds that may be authorized in any Long-Term
3831 Care Planning District during any fiscal year shall not exceed
3832 forty (40) beds. Of the certificates of need that are issued for
3833 each Long-Term Care Planning District during the next two (2)
3834 fiscal years, at least one (1) shall be issued for beds in the
3835 northern part of the district, at least one (1) shall be issued
3836 for beds in the central part of the district, and at least one (1)
3837 shall be issued for beds in the southern part of the district.

3838 (iii) The State Department of Health, in
3839 consultation with the Department of Mental Health and the Division
3840 of Medicaid, shall develop and prescribe the staffing levels,
3841 space requirements and other standards and requirements that must
3842 be met with regard to the nursing facility beds authorized under
3843 this paragraph (r) to provide care exclusively to patients with
3844 Alzheimer's disease.



3845 (s) The State Department of Health may issue a
3846 certificate of need to a nonprofit skilled nursing facility using
3847 the Green House model of skilled nursing care and located in Yazoo
3848 City, Yazoo County, Mississippi, for the construction, expansion
3849 or conversion of not more than nineteen (19) nursing facility
3850 beds. For purposes of this paragraph (s), the provisions of
3851 Section 41-7-193(1) requiring substantial compliance with the
3852 projection of need as reported in the current State Health Plan
3853 and the provisions of Section 41-7-197 requiring a formal
3854 certificate of need hearing process are waived. There shall be no
3855 prohibition or restrictions on participation in the Medicaid
3856 program for the person receiving the certificate of need
3857 authorized under this paragraph (s).

3858 (t) The State Department of Health shall issue
3859 certificates of need to the owner of a nursing facility in
3860 operation at the time of Hurricane Katrina in Hancock County that
3861 was not operational on December 31, 2005, because of damage
3862 sustained from Hurricane Katrina to authorize the following: (i)
3863 the construction of a new nursing facility in Harrison County;
3864 (ii) the relocation of forty-nine (49) nursing facility beds from
3865 the Hancock County facility to the new Harrison County facility;
3866 (iii) the establishment of not more than twenty (20) non-Medicaid
3867 nursing facility beds at the Hancock County facility; and (iv) the
3868 establishment of not more than twenty (20) non-Medicaid beds at
3869 the new Harrison County facility. The certificates of need that



3870 authorize the non-Medicaid nursing facility beds under
3871 subparagraphs (iii) and (iv) of this paragraph (t) shall be
3872 subject to the following conditions: The owner of the Hancock
3873 County facility and the new Harrison County facility must agree in
3874 writing that no more than fifty (50) of the beds at the Hancock
3875 County facility and no more than forty-nine (49) of the beds at
3876 the Harrison County facility will be certified for participation
3877 in the Medicaid program, and that no claim will be submitted for
3878 Medicaid reimbursement for more than fifty (50) patients in the
3879 Hancock County facility in any month, or for more than forty-nine
3880 (49) patients in the Harrison County facility in any month, or for
3881 any patient in either facility who is in a bed that is not
3882 Medicaid-certified. This written agreement by the owner of the
3883 nursing facilities shall be a condition of the issuance of the
3884 certificates of need under this paragraph (t), and the agreement
3885 shall be fully binding on any later owner or owners of either
3886 facility if the ownership of either facility is transferred at any
3887 time after the certificates of need are issued. After this
3888 written agreement is executed, the Division of Medicaid and the
3889 State Department of Health shall not certify more than fifty (50)
3890 of the beds at the Hancock County facility or more than forty-nine
3891 (49) of the beds at the Harrison County facility for participation
3892 in the Medicaid program. If the Hancock County facility violates
3893 the terms of the written agreement by admitting or keeping in the
3894 facility on a regular or continuing basis more than fifty (50)



3895 patients who are participating in the Medicaid program, or if the
3896 Harrison County facility violates the terms of the written
3897 agreement by admitting or keeping in the facility on a regular or
3898 continuing basis more than forty-nine (49) patients who are
3899 participating in the Medicaid program, the State Department of
3900 Health shall revoke the license of the facility that is in
3901 violation of the agreement, at the time that the department
3902 determines, after a hearing complying with due process, that the
3903 facility has violated the agreement.

3904 (u) The State Department of Health shall issue a
3905 certificate of need to a nonprofit venture for the establishment,
3906 construction and operation of a skilled nursing facility of not
3907 more than sixty (60) beds to provide skilled nursing care for
3908 ventilator dependent or otherwise medically dependent pediatric
3909 patients who require medical and nursing care or rehabilitation
3910 services to be located in a county in which an academic medical
3911 center and a children's hospital are located, and for any
3912 construction and for the acquisition of equipment related to those
3913 beds. The facility shall be authorized to keep such ventilator
3914 dependent or otherwise medically dependent pediatric patients
3915 beyond age twenty-one (21) in accordance with regulations of the
3916 State Board of Health. For purposes of this paragraph (u), the
3917 provisions of Section 41-7-193(1) requiring substantial compliance
3918 with the projection of need as reported in the current State
3919 Health Plan are waived, and the provisions of Section 41-7-197



3920 requiring a formal certificate of need hearing process are waived.
3921 The beds authorized by this paragraph shall be counted as
3922 pediatric skilled nursing facility beds for health planning
3923 purposes under Section 41-7-171 et seq. There shall be no
3924 prohibition of or restrictions on participation in the Medicaid
3925 program for the person receiving the certificate of need
3926 authorized by this paragraph.

3927 (3) The State Department of Health may grant approval for
3928 and issue certificates of need to any person proposing the new
3929 construction of, addition to, conversion of beds of or expansion
3930 of any health care facility defined in subparagraph (x)
3931 (psychiatric residential treatment facility) of Section
3932 41-7-173(h). The total number of beds which may be authorized by
3933 such certificates of need shall not exceed three hundred
3934 thirty-four (334) beds for the entire state.

3935 (a) Of the total number of beds authorized under this
3936 subsection, the department shall issue a certificate of need to a
3937 privately owned psychiatric residential treatment facility in
3938 Simpson County for the conversion of sixteen (16) intermediate
3939 care facility for individuals with intellectual disabilities
3940 (ICF-IID) beds to psychiatric residential treatment facility beds,
3941 provided that facility agrees in writing that the facility shall
3942 give priority for the use of those sixteen (16) beds to
3943 Mississippi residents who are presently being treated in
3944 out-of-state facilities.



3945 (b) Of the total number of beds authorized under this
3946 subsection, the department may issue a certificate or certificates
3947 of need for the construction or expansion of psychiatric
3948 residential treatment facility beds or the conversion of other
3949 beds to psychiatric residential treatment facility beds in Warren
3950 County, not to exceed sixty (60) psychiatric residential treatment
3951 facility beds, provided that the facility agrees in writing that
3952 no more than thirty (30) of the beds at the psychiatric
3953 residential treatment facility will be certified for participation
3954 in the Medicaid program (Section 43-13-101 et seq.) for the use of
3955 any patients other than those who are participating only in the
3956 Medicaid program of another state, and that no claim will be
3957 submitted to the Division of Medicaid for Medicaid reimbursement
3958 for more than thirty (30) patients in the psychiatric residential
3959 treatment facility in any day or for any patient in the
3960 psychiatric residential treatment facility who is in a bed that is
3961 not Medicaid-certified. This written agreement by the recipient
3962 of the certificate of need shall be a condition of the issuance of
3963 the certificate of need under this paragraph, and the agreement
3964 shall be fully binding on any subsequent owner of the psychiatric
3965 residential treatment facility if the ownership of the facility is
3966 transferred at any time after the issuance of the certificate of
3967 need. After this written agreement is executed, the Division of
3968 Medicaid and the State Department of Health shall not certify more
3969 than thirty (30) of the beds in the psychiatric residential



3970 treatment facility for participation in the Medicaid program for
3971 the use of any patients other than those who are participating
3972 only in the Medicaid program of another state. If the psychiatric
3973 residential treatment facility violates the terms of the written
3974 agreement by admitting or keeping in the facility on a regular or
3975 continuing basis more than thirty (30) patients who are
3976 participating in the Mississippi Medicaid program, the State
3977 Department of Health shall revoke the license of the facility, at
3978 the time that the department determines, after a hearing complying
3979 with due process, that the facility has violated the condition
3980 upon which the certificate of need was issued, as provided in this
3981 paragraph and in the written agreement.

3982 The State Department of Health, on or before July 1, 2002,
3983 shall transfer the certificate of need authorized under the
3984 authority of this paragraph (b), or reissue the certificate of
3985 need if it has expired, to River Region Health System.

3986 (c) Of the total number of beds authorized under this
3987 subsection, the department shall issue a certificate of need to a
3988 hospital currently operating Medicaid-certified acute psychiatric
3989 beds for adolescents in DeSoto County, for the establishment of a
3990 forty-bed psychiatric residential treatment facility in DeSoto
3991 County * * *, ~~provided that the hospital agrees in writing (i)~~
3992 ~~that the hospital shall give priority for the use of those forty~~
3993 ~~(40) beds to Mississippi residents who are presently being treated~~
3994 ~~in out-of-state facilities, and (ii) that no more than fifteen~~



3995 ~~(15) of the beds at the psychiatric residential treatment facility~~
3996 ~~will be certified for participation in the Medicaid program~~
3997 ~~(Section 43-13-101 et seq.), and that no claim will be submitted~~
3998 ~~for Medicaid reimbursement for more than fifteen (15) patients in~~
3999 ~~the psychiatric residential treatment facility in any day or for~~
4000 ~~any patient in the psychiatric residential treatment facility who~~
4001 ~~is in a bed that is not Medicaid-certified. This written~~
4002 ~~agreement by the recipient of the certificate of need shall be a~~
4003 ~~condition of the issuance of the certificate of need under this~~
4004 ~~paragraph, and the agreement shall be fully binding on any~~
4005 ~~subsequent owner of the psychiatric residential treatment facility~~
4006 ~~if the ownership of the facility is transferred at any time after~~
4007 ~~the issuance of the certificate of need. After this written~~
4008 ~~agreement is executed, the Division of Medicaid and the State~~
4009 ~~Department of Health shall not certify more than fifteen (15) of~~
4010 ~~the beds in the psychiatric residential treatment facility for~~
4011 ~~participation in the Medicaid program. If the psychiatric~~
4012 ~~residential treatment facility violates the terms of the written~~
4013 ~~agreement by admitting or keeping in the facility on a regular or~~
4014 ~~continuing basis more than fifteen (15) patients who are~~
4015 ~~participating in the Medicaid program, the State Department of~~
4016 ~~Health shall revoke the license of the facility, at the time that~~
4017 ~~the department determines, after a hearing complying with due~~
4018 ~~process, that the facility has violated the condition upon which~~
4019 ~~the certificate of need was issued, as provided in this paragraph~~



4020 ~~and in the written agreement.~~ There shall be no prohibition or
4021 restrictions on participation in the Medicaid program (Section
4022 43-13-101 et seq.) for the person(s) receiving the certificate of
4023 need authorized under this paragraph (c) or for the beds converted
4024 pursuant to the authority of that certificate of need that would
4025 not apply to any other psychiatric residential treatment facility.

4026 (d) Of the total number of beds authorized under this
4027 subsection, the department may issue a certificate or certificates
4028 of need for the construction or expansion of psychiatric
4029 residential treatment facility beds or the conversion of other
4030 beds to psychiatric treatment facility beds, not to exceed thirty
4031 (30) psychiatric residential treatment facility beds, in either
4032 Alcorn, Tishomingo, Prentiss, Lee, Itawamba, Monroe, Chickasaw,
4033 Pontotoc, Calhoun, Lafayette, Union, Benton or Tippah County.

4034 (e) Of the total number of beds authorized under this
4035 subsection (3) the department shall issue a certificate of need to
4036 a privately owned, nonprofit psychiatric residential treatment
4037 facility in Hinds County for an eight-bed expansion of the
4038 facility, provided that the facility agrees in writing that the
4039 facility shall give priority for the use of those eight (8) beds
4040 to Mississippi residents who are presently being treated in
4041 out-of-state facilities.

4042 (f) The department shall issue a certificate of need to
4043 a one-hundred-thirty-four-bed specialty hospital located on
4044 twenty-nine and forty-four one-hundredths (29.44) commercial acres



4045 at 5900 Highway 39 North in Meridian (Lauderdale County),
4046 Mississippi, for the addition, construction or expansion of
4047 child/adolescent psychiatric residential treatment facility beds
4048 in Lauderdale County. As a condition of issuance of the
4049 certificate of need under this paragraph, the facility shall give
4050 priority in admissions to the child/adolescent psychiatric
4051 residential treatment facility beds authorized under this
4052 paragraph to patients who otherwise would require out-of-state
4053 placement. The Division of Medicaid, in conjunction with the
4054 Department of Human Services, shall furnish the facility a list of
4055 all out-of-state patients on a quarterly basis. Furthermore,
4056 notice shall also be provided to the parent, custodial parent or
4057 guardian of each out-of-state patient notifying them of the
4058 priority status granted by this paragraph. For purposes of this
4059 paragraph, the provisions of Section 41-7-193(1) requiring
4060 substantial compliance with the projection of need as reported in
4061 the current State Health Plan are waived. The total number of
4062 child/adolescent psychiatric residential treatment facility beds
4063 that may be authorized under the authority of this paragraph shall
4064 be sixty (60) beds. There shall be no prohibition or restrictions
4065 on participation in the Medicaid program (Section 43-13-101 et
4066 seq.) for the person receiving the certificate of need authorized
4067 under this paragraph or for the beds converted pursuant to the
4068 authority of that certificate of need.



4069 (4) (a) From and after March 25, 2021, the department may
4070 issue a certificate of need to any person for the new construction
4071 of any hospital, psychiatric hospital or chemical dependency
4072 hospital that will contain any child/adolescent psychiatric or
4073 child/adolescent chemical dependency beds, or for the conversion
4074 of any other health care facility to a hospital, psychiatric
4075 hospital or chemical dependency hospital that will contain any
4076 child/adolescent psychiatric or child/adolescent chemical
4077 dependency beds. There shall be no prohibition or restrictions on
4078 participation in the Medicaid program (Section 43-13-101 et seq.)
4079 for the person(s) receiving the certificate(s) of need authorized
4080 under this paragraph (a) or for the beds converted pursuant to the
4081 authority of that certificate of need. In issuing any new
4082 certificate of need for any child/adolescent psychiatric or
4083 child/adolescent chemical dependency beds, either by new
4084 construction or conversion of beds of another category, the
4085 department shall give preference to beds which will be located in
4086 an area of the state which does not have such beds located in it,
4087 and to a location more than sixty-five (65) miles from existing
4088 beds. Upon receiving 2020 census data, the department may amend
4089 the State Health Plan regarding child/adolescent psychiatric and
4090 child/adolescent chemical dependency beds to reflect the need
4091 based on new census data.

4092 (i) [Deleted]



4093 (ii) The department may issue a certificate of
4094 need for the conversion of existing beds in a county hospital in
4095 Choctaw County from acute care beds to child/adolescent chemical
4096 dependency beds. For purposes of this subparagraph (ii), the
4097 provisions of Section 41-7-193(1) requiring substantial compliance
4098 with the projection of need as reported in the current State
4099 Health Plan are waived. The total number of beds that may be
4100 authorized under authority of this subparagraph shall not exceed
4101 twenty (20) beds. There shall be no prohibition or restrictions
4102 on participation in the Medicaid program (Section 43-13-101 et
4103 seq.) for the hospital receiving the certificate of need
4104 authorized under this subparagraph or for the beds converted
4105 pursuant to the authority of that certificate of need.

4106 (iii) The department may issue a certificate or
4107 certificates of need for the construction or expansion of
4108 child/adolescent psychiatric beds or the conversion of other beds
4109 to child/adolescent psychiatric beds in Warren County. For
4110 purposes of this subparagraph (iii), the provisions of Section
4111 41-7-193(1) requiring substantial compliance with the projection
4112 of need as reported in the current State Health Plan are waived.
4113 The total number of beds that may be authorized under the
4114 authority of this subparagraph shall not exceed twenty (20) beds.
4115 There shall be no prohibition or restrictions on participation in
4116 the Medicaid program (Section 43-13-101 et seq.) for the person
4117 receiving the certificate of need authorized under this



4118 subparagraph or for the beds converted pursuant to the authority
4119 of that certificate of need.

4120 If by January 1, 2002, there has been no significant
4121 commencement of construction of the beds authorized under this
4122 subparagraph (iii), or no significant action taken to convert
4123 existing beds to the beds authorized under this subparagraph, then
4124 the certificate of need that was previously issued under this
4125 subparagraph shall expire. If the previously issued certificate
4126 of need expires, the department may accept applications for
4127 issuance of another certificate of need for the beds authorized
4128 under this subparagraph, and may issue a certificate of need to
4129 authorize the construction, expansion or conversion of the beds
4130 authorized under this subparagraph.

4131 (iv) The department shall issue a certificate of
4132 need to the Region 7 Mental Health/Retardation Commission for the
4133 construction or expansion of child/adolescent psychiatric beds or
4134 the conversion of other beds to child/adolescent psychiatric beds
4135 in any of the counties served by the commission. For purposes of
4136 this subparagraph (iv), the provisions of Section 41-7-193(1)
4137 requiring substantial compliance with the projection of need as
4138 reported in the current State Health Plan are waived. The total
4139 number of beds that may be authorized under the authority of this
4140 subparagraph shall not exceed twenty (20) beds. There shall be no
4141 prohibition or restrictions on participation in the Medicaid
4142 program (Section 43-13-101 et seq.) for the person receiving the



4143 certificate of need authorized under this subparagraph or for the
4144 beds converted pursuant to the authority of that certificate of
4145 need.

4146 (v) The department may issue a certificate of need
4147 to any county hospital located in Leflore County for the
4148 construction or expansion of adult psychiatric beds or the
4149 conversion of other beds to adult psychiatric beds, not to exceed
4150 twenty (20) beds, provided that the recipient of the certificate
4151 of need agrees in writing that the adult psychiatric beds will not
4152 at any time be certified for participation in the Medicaid program
4153 and that the hospital will not admit or keep any patients who are
4154 participating in the Medicaid program in any of such adult
4155 psychiatric beds. This written agreement by the recipient of the
4156 certificate of need shall be fully binding on any subsequent owner
4157 of the hospital if the ownership of the hospital is transferred at
4158 any time after the issuance of the certificate of need. Agreement
4159 that the adult psychiatric beds will not be certified for
4160 participation in the Medicaid program shall be a condition of the
4161 issuance of a certificate of need to any person under this
4162 subparagraph (v), and if such hospital at any time after the
4163 issuance of the certificate of need, regardless of the ownership
4164 of the hospital, has any of such adult psychiatric beds certified
4165 for participation in the Medicaid program or admits or keeps any
4166 Medicaid patients in such adult psychiatric beds, the State
4167 Department of Health shall revoke the certificate of need, if it



4168 is still outstanding, and shall deny or revoke the license of the
4169 hospital at the time that the department determines, after a
4170 hearing complying with due process, that the hospital has failed
4171 to comply with any of the conditions upon which the certificate of
4172 need was issued, as provided in this subparagraph and in the
4173 written agreement by the recipient of the certificate of need.

4174 (vi) The department may issue a certificate or
4175 certificates of need for the expansion of child psychiatric beds
4176 or the conversion of other beds to child psychiatric beds at the
4177 University of Mississippi Medical Center. For purposes of this
4178 subparagraph (vi), the provisions of Section 41-7-193(1) requiring
4179 substantial compliance with the projection of need as reported in
4180 the current State Health Plan are waived. The total number of
4181 beds that may be authorized under the authority of this
4182 subparagraph shall not exceed fifteen (15) beds. There shall be
4183 no prohibition or restrictions on participation in the Medicaid
4184 program (Section 43-13-101 et seq.) for the hospital receiving the
4185 certificate of need authorized under this subparagraph or for the
4186 beds converted pursuant to the authority of that certificate of
4187 need.

4188 (b) From and after July 1, 1990, no hospital,
4189 psychiatric hospital or chemical dependency hospital shall be
4190 authorized to add any child/adolescent psychiatric or
4191 child/adolescent chemical dependency beds or convert any beds of
4192 another category to child/adolescent psychiatric or



4193 child/adolescent chemical dependency beds without a certificate of
4194 need under the authority of subsection (1)(c) and subsection
4195 (4)(a) of this section.

4196 (5) The department may issue a certificate of need to a
4197 county hospital in Winston County for the conversion of fifteen
4198 (15) acute care beds to geriatric psychiatric care beds.

4199 (6) The State Department of Health shall issue a certificate
4200 of need to a Mississippi corporation qualified to manage a
4201 long-term care hospital as defined in Section 41-7-173(h)(xii) in
4202 Harrison County, not to exceed eighty (80) beds, including any
4203 necessary renovation or construction required for licensure and
4204 certification, provided that the recipient of the certificate of
4205 need agrees in writing that the long-term care hospital will not
4206 at any time participate in the Medicaid program (Section 43-13-101
4207 et seq.) or admit or keep any patients in the long-term care
4208 hospital who are participating in the Medicaid program. This
4209 written agreement by the recipient of the certificate of need
4210 shall be fully binding on any subsequent owner of the long-term
4211 care hospital, if the ownership of the facility is transferred at
4212 any time after the issuance of the certificate of need. Agreement
4213 that the long-term care hospital will not participate in the
4214 Medicaid program shall be a condition of the issuance of a
4215 certificate of need to any person under this subsection (6), and
4216 if such long-term care hospital at any time after the issuance of
4217 the certificate of need, regardless of the ownership of the



4218 facility, participates in the Medicaid program or admits or keeps
4219 any patients in the facility who are participating in the Medicaid
4220 program, the State Department of Health shall revoke the
4221 certificate of need, if it is still outstanding, and shall deny or
4222 revoke the license of the long-term care hospital, at the time
4223 that the department determines, after a hearing complying with due
4224 process, that the facility has failed to comply with any of the
4225 conditions upon which the certificate of need was issued, as
4226 provided in this subsection and in the written agreement by the
4227 recipient of the certificate of need. For purposes of this
4228 subsection, the provisions of Section 41-7-193(1) requiring
4229 substantial compliance with the projection of need as reported in
4230 the current State Health Plan are waived.

4231 (7) The State Department of Health may issue a certificate
4232 of need to any hospital in the state to utilize a portion of its
4233 beds for the "swing-bed" concept. Any such hospital must be in
4234 conformance with the federal regulations regarding such swing-bed
4235 concept at the time it submits its application for a certificate
4236 of need to the State Department of Health, except that such
4237 hospital may have more licensed beds or a higher average daily
4238 census (ADC) than the maximum number specified in federal
4239 regulations for participation in the swing-bed program. Any
4240 hospital meeting all federal requirements for participation in the
4241 swing-bed program which receives such certificate of need shall
4242 render services provided under the swing-bed concept to any



4243 patient eligible for Medicare (Title XVIII of the Social Security
4244 Act) who is certified by a physician to be in need of such
4245 services, and no such hospital shall permit any patient who is
4246 eligible for both Medicaid and Medicare or eligible only for
4247 Medicaid to stay in the swing beds of the hospital for more than
4248 thirty (30) days per admission unless the hospital receives prior
4249 approval for such patient from the Division of Medicaid, Office of
4250 the Governor. Any hospital having more licensed beds or a higher
4251 average daily census (ADC) than the maximum number specified in
4252 federal regulations for participation in the swing-bed program
4253 which receives such certificate of need shall develop a procedure
4254 to ensure that before a patient is allowed to stay in the swing
4255 beds of the hospital, there are no vacant nursing home beds
4256 available for that patient located within a fifty-mile radius of
4257 the hospital. When any such hospital has a patient staying in the
4258 swing beds of the hospital and the hospital receives notice from a
4259 nursing home located within such radius that there is a vacant bed
4260 available for that patient, the hospital shall transfer the
4261 patient to the nursing home within a reasonable time after receipt
4262 of the notice. Any hospital which is subject to the requirements
4263 of the two (2) preceding sentences of this subsection may be
4264 suspended from participation in the swing-bed program for a
4265 reasonable period of time by the State Department of Health if the
4266 department, after a hearing complying with due process, determines



4267 that the hospital has failed to comply with any of those
4268 requirements.

4269 (8) The Department of Health shall not grant approval for or
4270 issue a certificate of need to any person proposing the new
4271 construction of, addition to or expansion of a health care
4272 facility as defined in subparagraph (viii) of Section 41-7-173(h),
4273 except as hereinafter provided: The department may issue a
4274 certificate of need to a nonprofit corporation located in Madison
4275 County, Mississippi, for the construction, expansion or conversion
4276 of not more than twenty (20) beds in a community living program
4277 for developmentally disabled adults in a facility as defined in
4278 subparagraph (viii) of Section 41-7-173(h). For purposes of this
4279 subsection (8), the provisions of Section 41-7-193(1) requiring
4280 substantial compliance with the projection of need as reported in
4281 the current State Health Plan and the provisions of Section
4282 41-7-197 requiring a formal certificate of need hearing process
4283 are waived. There shall be no prohibition or restrictions on
4284 participation in the Medicaid program for the person receiving the
4285 certificate of need authorized under this subsection (8).

4286 (9) The Department of Health shall not grant approval for or
4287 issue a certificate of need to any person proposing the
4288 establishment of, or expansion of the currently approved territory
4289 of, or the contracting to establish a home office, subunit or
4290 branch office within the space operated as a health care facility
4291 as defined in Section 41-7-173(h) (i) through (viii) by a health



4292 care facility as defined in subparagraph (ix) of Section
4293 41-7-173(h).

4294 (10) Health care facilities owned and/or operated by the
4295 state or its agencies are exempt from the restraints in this
4296 section against issuance of a certificate of need if such addition
4297 or expansion consists of repairing or renovation necessary to
4298 comply with the state licensure law. This exception shall not
4299 apply to the new construction of any building by such state
4300 facility. This exception shall not apply to any health care
4301 facilities owned and/or operated by counties, municipalities,
4302 districts, unincorporated areas, other defined persons, or any
4303 combination thereof.

4304 (11) The new construction, renovation or expansion of or
4305 addition to any health care facility defined in subparagraph (ii)
4306 (psychiatric hospital), subparagraph (iv) (skilled nursing
4307 facility), subparagraph (vi) (intermediate care facility),
4308 subparagraph (viii) (intermediate care facility for individuals
4309 with intellectual disabilities) and subparagraph (x) (psychiatric
4310 residential treatment facility) of Section 41-7-173(h) which is
4311 owned by the State of Mississippi and under the direction and
4312 control of the State Department of Mental Health, and the addition
4313 of new beds or the conversion of beds from one category to another
4314 in any such defined health care facility which is owned by the
4315 State of Mississippi and under the direction and control of the
4316 State Department of Mental Health, shall not require the issuance



4317 of a certificate of need under Section 41-7-171 et seq.,
4318 notwithstanding any provision in Section 41-7-171 et seq. to the
4319 contrary.

4320 (12) The new construction, renovation or expansion of or
4321 addition to any veterans homes or domiciliaries for eligible
4322 veterans of the State of Mississippi as authorized under Section
4323 35-1-19 shall not require the issuance of a certificate of need,
4324 notwithstanding any provision in Section 41-7-171 et seq. to the
4325 contrary.

4326 (13) The repair or the rebuilding of an existing, operating
4327 health care facility that sustained significant damage from a
4328 natural disaster that occurred after April 15, 2014, in an area
4329 that is proclaimed a disaster area or subject to a state of
4330 emergency by the Governor or by the President of the United States
4331 shall be exempt from all of the requirements of the Mississippi
4332 Certificate of Need Law (Section 41-7-171 et seq.) and any and all
4333 rules and regulations promulgated under that law, subject to the
4334 following conditions:

4335 (a) The repair or the rebuilding of any such damaged
4336 health care facility must be within one (1) mile of the
4337 pre-disaster location of the campus of the damaged health care
4338 facility, except that any temporary post-disaster health care
4339 facility operating location may be within five (5) miles of the
4340 pre-disaster location of the damaged health care facility;



4341 (b) The repair or the rebuilding of the damaged health
4342 care facility (i) does not increase or change the complement of
4343 its bed capacity that it had before the Governor's or the
4344 President's proclamation, (ii) does not increase or change its
4345 levels and types of health care services that it provided before
4346 the Governor's or the President's proclamation, and (iii) does not
4347 rebuild in a different county; however, this paragraph does not
4348 restrict or prevent a health care facility from decreasing its bed
4349 capacity that it had before the Governor's or the President's
4350 proclamation, or from decreasing the levels of or decreasing or
4351 eliminating the types of health care services that it provided
4352 before the Governor's or the President's proclamation, when the
4353 damaged health care facility is repaired or rebuilt;

4354 (c) The exemption from Certificate of Need Law provided
4355 under this subsection (13) is valid for only five (5) years from
4356 the date of the Governor's or the President's proclamation. If
4357 actual construction has not begun within that five-year period,
4358 the exemption provided under this subsection is inapplicable; and

4359 (d) The Division of Health Facilities Licensure and
4360 Certification of the State Department of Health shall provide the
4361 same oversight for the repair or the rebuilding of the damaged
4362 health care facility that it provides to all health care facility
4363 construction projects in the state.

4364 For the purposes of this subsection (13), "significant
4365 damage" to a health care facility means damage to the health care



4366 facility requiring an expenditure of at least One Million Dollars
4367 (\$1,000,000.00).

4368 (14) The State Department of Health shall issue a
4369 certificate of need to any hospital which is currently licensed
4370 for two hundred fifty (250) or more acute care beds and is located
4371 in any general hospital service area not having a comprehensive
4372 cancer center, for the establishment and equipping of such a
4373 center which provides facilities and services for outpatient
4374 radiation oncology therapy, outpatient medical oncology therapy,
4375 and appropriate support services including the provision of
4376 radiation therapy services. The provisions of Section 41-7-193(1)
4377 regarding substantial compliance with the projection of need as
4378 reported in the current State Health Plan are waived for the
4379 purpose of this subsection.

4380 (15) The State Department of Health may authorize the
4381 transfer of hospital beds, not to exceed sixty (60) beds, from the
4382 North Panola Community Hospital to the South Panola Community
4383 Hospital. The authorization for the transfer of those beds shall
4384 be exempt from the certificate of need review process.

4385 (16) The State Department of Health shall issue any
4386 certificates of need necessary for Mississippi State University
4387 and a public or private health care provider to jointly acquire
4388 and operate a linear accelerator and a magnetic resonance imaging
4389 unit. Those certificates of need shall cover all capital
4390 expenditures related to the project between Mississippi State



4391 University and the health care provider, including, but not
4392 limited to, the acquisition of the linear accelerator, the
4393 magnetic resonance imaging unit and other radiological modalities;
4394 the offering of linear accelerator and magnetic resonance imaging
4395 services; and the cost of construction of facilities in which to
4396 locate these services. The linear accelerator and the magnetic
4397 resonance imaging unit shall be (a) located in the City of
4398 Starkville, Oktibbeha County, Mississippi; (b) operated jointly by
4399 Mississippi State University and the public or private health care
4400 provider selected by Mississippi State University through a
4401 request for proposals (RFP) process in which Mississippi State
4402 University selects, and the Board of Trustees of State
4403 Institutions of Higher Learning approves, the health care provider
4404 that makes the best overall proposal; (c) available to Mississippi
4405 State University for research purposes two-thirds (2/3) of the
4406 time that the linear accelerator and magnetic resonance imaging
4407 unit are operational; and (d) available to the public or private
4408 health care provider selected by Mississippi State University and
4409 approved by the Board of Trustees of State Institutions of Higher
4410 Learning one-third (1/3) of the time for clinical, diagnostic and
4411 treatment purposes. For purposes of this subsection, the
4412 provisions of Section 41-7-193(1) requiring substantial compliance
4413 with the projection of need as reported in the current State
4414 Health Plan are waived.



4415 (17) The State Department of Health shall issue a
4416 certificate of need for the construction of an acute care hospital
4417 in Kemper County, not to exceed twenty-five (25) beds, which shall
4418 be named the "John C. Stennis Memorial Hospital." In issuing the
4419 certificate of need under this subsection, the department shall
4420 give priority to a hospital located in Lauderdale County that has
4421 two hundred fifteen (215) beds. For purposes of this subsection,
4422 the provisions of Section 41-7-193(1) requiring substantial
4423 compliance with the projection of need as reported in the current
4424 State Health Plan and the provisions of Section 41-7-197 requiring
4425 a formal certificate of need hearing process are waived. There
4426 shall be no prohibition or restrictions on participation in the
4427 Medicaid program (Section 43-13-101 et seq.) for the person or
4428 entity receiving the certificate of need authorized under this
4429 subsection or for the beds constructed under the authority of that
4430 certificate of need.

4431 (18) The planning, design, construction, renovation,
4432 addition, furnishing and equipping of a clinical research unit at
4433 any health care facility defined in Section 41-7-173(h) that is
4434 under the direction and control of the University of Mississippi
4435 Medical Center and located in Jackson, Mississippi, and the
4436 addition of new beds or the conversion of beds from one (1)
4437 category to another in any such clinical research unit, shall not
4438 require the issuance of a certificate of need under Section



4439 41-7-171 et seq., notwithstanding any provision in Section
4440 41-7-171 et seq. to the contrary.

4441 (19) [Repealed]

4442 (20) Nothing in this section or in any other provision of
4443 Section 41-7-171 et seq. shall prevent any nursing facility from
4444 designating an appropriate number of existing beds in the facility
4445 as beds for providing care exclusively to patients with
4446 Alzheimer's disease.

4447 (21) Nothing in this section or any other provision of
4448 Section 41-7-171 et seq. shall prevent any health care facility
4449 from the new construction, renovation, conversion or expansion of
4450 new beds in the facility designated as intensive care units,
4451 negative pressure rooms, or isolation rooms pursuant to the
4452 provisions of Sections 41-14-1 through 41-14-11, or Section
4453 41-14-31. For purposes of this subsection, the provisions of
4454 Section 41-7-193(1) requiring substantial compliance with the
4455 projection of need as reported in the current State Health Plan
4456 and the provisions of Section 41-7-197 requiring a formal
4457 certificate of need hearing process are waived.

4458 **SECTION 14.** The following shall be codified as Section
4459 83-9-47, Mississippi Code of 1972:

4460 83-9-47. (1) An insurer providing coverage for prescription
4461 drugs shall not require or impose any step therapy protocol with
4462 respect to a drug that is approved by the United States Food and
4463 Drug Administration for the treatment of postpartum depression.



4464 (2) As used in this section, "insurer" means any hospital,
4465 health or medical expense insurance policy, hospital or medical
4466 service contract, employee welfare benefit plan, contract or
4467 agreement with a health maintenance organization or a preferred
4468 provider organization, health and accident insurance policy, or
4469 any other insurance contract of this type, including a group
4470 insurance plan. However, the term "insurer" does not include a
4471 preferred provider organization that is only a network of
4472 providers and does not define health care benefits for the purpose
4473 of coverage under a health care benefits plan.

4474 **SECTION 15.** The following shall be codified as Section
4475 41-140-1, Mississippi Code of 1972:

4476 41-140-1. **Definitions.** (1) "Maternal health care facility"
4477 means any facility that provides prenatal or perinatal care,
4478 including, but not limited to, hospitals, clinics and other
4479 physician facilities.

4480 (2) "Maternal health care provider" means any physician,
4481 nurse or other authorized practitioner that attends to pregnant
4482 women and mothers of infants.

4483 **SECTION 16.** The following shall be codified as Section
4484 41-140-3, Mississippi Code of 1972:

4485 41-140-3. **Education and awareness.** (1) The State
4486 Department of Health shall develop written educational materials
4487 and information for health care professionals and patients about



4488 maternal mental health conditions, including postpartum
4489 depression.

4490 (a) The materials shall include information on the
4491 symptoms and methods of coping with postpartum depression, as well
4492 treatment options and resources;

4493 (b) The State Department of Health shall periodically
4494 review the materials and information to determine their
4495 effectiveness and ensure they reflect the most up-to-date and
4496 accurate information;

4497 (c) The State Department of Health shall post on its
4498 website the materials and information; and

4499 (d) The State Department of Health shall make available
4500 or distribute the materials and information in physical form upon
4501 request.

4502 (2) Hospitals that provide birth services shall provide
4503 departing new parents and other family members, as appropriate,
4504 with written materials and information developed under subsection
4505 (1) of this section, upon discharge from such institution.

4506 (3) Any facility, physician, health care provider or nurse
4507 midwife who renders prenatal care, postnatal care, or pediatric
4508 infant care, shall provide the materials and information developed
4509 under subsection (1)(a) of this section, to any woman who presents
4510 with signs of a maternal mental health disorder.

4511 **SECTION 17.** The following shall be codified as Section
4512 41-140-5, Mississippi Code of 1972:



4513 41-140-5. **Screening and linkage to care.** (1) Any
4514 physician, health care provider, or nurse midwife who renders
4515 postnatal care or who provides pediatric infant care shall ensure
4516 that the postnatal care patient or birthing mother of the
4517 pediatric infant care patient, as applicable, is offered screening
4518 for postpartum depression, and, if such patient or birthing mother
4519 does not object to such screening, shall ensure that such patient
4520 or birthing mother is appropriately screened for postpartum
4521 depression in line with evidence-based guidelines, such as the
4522 Bright Futures Toolkit developed by the American Academy of
4523 Pediatrics.

4524 (2) If a health care provider administering screening in
4525 accordance with this section determines, based on the screening
4526 methodology administered, that the postnatal care patient or
4527 birthing mother of the pediatric infant care patient is likely to
4528 be suffering from postpartum depression, such health care provider
4529 shall provide appropriate referrals, including discussion of
4530 available treatments for postpartum depression, including
4531 pharmacological treatments.

4532 **SECTION 18.** The following shall be codified as Section
4533 83-9-48, Mississippi Code of 1972:

4534 83-9-48. **Coverage of screening for postpartum depression.**

4535 (1) An insurer shall provide coverage for postpartum depression
4536 screening required pursuant to Section 41-140-3. Such coverage
4537 shall provide for additional reimbursement for the administration



4538 of postpartum depression screening adequate to compensate the
4539 health care provider for the provision of such screening and
4540 consistent with ensuring broad access to postpartum depression
4541 screening in line with evidence-based guidelines.

4542 (2) As used in this section, "insurer" means any hospital,
4543 health or medical expense insurance policy, hospital or medical
4544 service contract, employee welfare benefit plan, contract or
4545 agreement with a health maintenance organization or a preferred
4546 provider organization, health and accident insurance policy, or
4547 any other insurance contract of this type, including a group
4548 insurance plan. However, the term "insurer" does not include a
4549 preferred provider organization that is only a network of
4550 providers and does not define health care benefits for the purpose
4551 of coverage under a health care benefits plan.

4552 **SECTION 19.** This act shall take effect and be in force from
4553 and after its passage.

