Title 15 - Mississippi State Department of Health

Part 9: Office of Health Policy and Planning

Subpart 91: Planning & Resource Development

CHAPTER 1 - POLICIES, PROCEDURES AND DEFINITIONS

1.1 General Statement of Public Policy

Section 41-7-171 et seq., Mississippi Code of 1972 Annotated, as amended, established the Mississippi Department of Health (Department) as the sole and official agency of the State of Mississippi to administer and supervise all state health planning and development responsibilities of the State of Mississippi.

The intention of health planning and health regulatory activities is to prevent unnecessary duplication of health resources; provide cost containment, improve the health of Mississippi residents; and increase the accessibility, acceptability, continuity and quality of health services. The regulatory mechanism to achieve these results is the Certificate of Need (CON).

A CON must be obtained from the Department before undertaking any of the activities described in Section 41-7-191 (1) without obtaining a Certificate of Need (CON) from the Department. No final arrangement or commitment for financing such activity may be made by any person unless a CON for such arrangement or commitment has been issued by the Department. The Department will only issue a CON for new institutional health services and other proposals which are determined to be needed pursuant to statutory requirements. Only those proposals granted a CON may be developed or offered within the State of Mississippi.

Only the Department, acting in response to an application for a certificate of need, or in response to a decision of a court of competent jurisdiction, may cause a CON to be issued, denied, or withdrawn or may determine that CON review is not required. In carrying out these responsibilities, the Department shall make decisions to issue or withdraw a CON by conducting the review of each application in accordance with the adopted procedures, standards, and criteria.

No CON shall be issued unless the action proposed in the application for such Certificate has been reviewed for consistency with the specifications and criteria established by the Department and substantially complies with the projection of need as reported in the ***State Health Plan*** which is in effect at the time the application is received by the Department.

The Department will disapprove a CON application if the applicant fails to provide or confirm that the applicant shall provide a reasonable amount of indigent care or has admission policies which deny access to care by indigent patients.

The Department will disapprove a CON application if approval of the request would have significant adverse effect on the ability of an existing facility or service to provide Medicaid/indigent care.

The State Health Officer shall determine whether the amount of indigent care provided or to be offered is "reasonable." The Department has determined that a reasonable amount of indigent care is an amount which is comparable to the amount of such care offered by other providers of the requested service within the same, or proximate, geographic area.

The Department shall adopt and revise as necessary criteria and review procedures for CON applications. Before review of new institutional health services or other proposals requiring a CON, the Department shall disseminate to all health care facilities and health maintenance organizations within the State and shall publish in The Clarion-Ledger (Jackson, Mississippi) and other newspapers deemed appropriate a description of the scope of coverage of the State Department of Health's Certificate of Need Program. Whenever the scope of such coverage is revised, the State Department of Health shall disseminate and publish a revised description in like manner.

Certificates of Need shall be issued by the State Health Officer based upon those criteria and standards established and lawfully adopted. Appropriate mechanisms for providing affected persons an opportunity for a formal hearing on matters to be considered by the State Department of Health have been developed. No CON shall be granted or denied until affected parties have been accorded such right to a formal hearing.

A CON is not transferable from one person or entity to another except with the approval of the Department. A CON shall be valid for a designated period of not more than one year from the effective date. The Department may extend the CON for a period not to exceed six months in those cases where the applicant shows to the satisfaction of the State Department of Health that a good faith effort has been made toward completion of the project.

All approved projects will be monitored by Department staff to assure compliance with stated policies, standards (including Life Safety, Construction, and Licensure), and approved costs.

Recipients of Certificates of Need are required to make written progress reports of their projects at least every six months and at completion.

NOTE: If any section, chapter, articles, paragraph, sentence, clause, phrase, rule or regulation, or any other part or portion of this State Certificate of Need Review Manual is declared by proper authority to be invalid or of no effect, the remainder hereof shall be in no manner affected thereby but shall remain in full force and effect.

Whenever or wherever the occasion may arise to present conflict between this State Certificate of Need Review Manual and legislative statutes, the legislative statutes shall prevail.

1.2 Applications Unacceptable for Certificate of Need Review

An application for a CON shall not be accepted from the same person for a proposal in a health planning area from which a previously submitted application for like or similar service or equipment, as determined by the Department, has been disapproved unless one or more of the following conditions exist:

1. A substantial change has occurred in existing or proposed health services of the type proposed by the applicant.

2. A substantial change has occurred in the need for the health service proposed by the applicant.

3. At least one year has elapsed from the date of the finding that resulted in disapproval of the previous application.

A substantial change in existing or proposed services or facilities shall mean the closure of the facility or service, or revocation of a CON, for that facility or service which, when taken into account, will result in an actual need for a facility or service. "Actual need" means need as reflected by the appropriate plans, standards, or criteria as reflected in the most recent or current version of the State Health Plan.

A substantial change in the need for the facility or service shall mean an amendment, correction, or replacement of a standard, criterion, or plan of the Department, which when taken into account, will result in an actual need for the type of service or facility proposed.

1.3 Procedures for Adoption and Revision of Certificate of Need Review Procedures and/or Review Criteria

The Mississippi Department of Health shall comply with the State of Mississippi Administrative Procedures Act in the event CON criteria and review procedures require revision or amendment.

Before review of new institutional health services or other proposals requiring a CON, the Department shall disseminate to all health care facilities and health maintenance organizations within the State and shall publish in The Clarion-Ledger (Jackson, Mississippi) and other newspapers as deemed appropriate a description of the scope of coverage of the Department's CON Program. Whenever the scope of such coverage is revised, the Department shall disseminate and publish a revised description in like manner.

Any person who is aggrieved by a proposed adoption or revision of review procedures or criteria shall submit in writing to the Department any objections to the proposed change or need for clarification.

A request for objection or clarification must be submitted to the Department of Health within thirty (30) calendar days after the Department has filed with the Office of the Secretary of State the proposed rule or rules.

1.4 Rules and Procedures for Conducting Meetings and Hearings

The Department shall conduct all meetings and hearings according to the provisions of its adopted rules and procedures.

If the Department rules and procedures are silent on any question, then the rules and procedures as stated in Robert's Rules of Order, Newly Revised (1990 Edition) and the latest version of the Mississippi Rules of Civil Procedure may be utilized.

In the event of conflict between the adopted rules and procedures of the Department and those outlined in Robert's Rules of Order or the Mississippi Rules of Civil Procedure, the rules and procedures adopted by the Department shall prevail.

1.5 Notice of Meeting

All CON meetings of the Department shall be open to the public. The public shall be notified of meetings of the Department through the Mississippi State Department of Health's website not less than ten (10) calendar days before such meetings are held. Public participation is encouraged.

Proof of publication of all hearings in accordance with the above paragraph shall be maintained in the Department's files.

The hearings shall be held in public in a facility of adequate space to accommodate all persons, including the public, reasonably expected to attend and shall be conducted according to the provisions of Section 25-41-1 et seq., Mississippi Code of 1972 Annotated, as amended.

Interested persons are welcome to attend CON review meetings of the Department and, at the discretion of the State Health Officer, may be allowed to address the Department on any item that is under consideration.

1.6 Agenda

The agenda for all business meetings and hearings shall be made available to the State Health Officer in advance. Copies of the agenda will be available to the public at the place of assembly and to applicants ten (10) calendar days before the meeting or hearing.

1.7 Certificate of Need Application Review

All CON applications will be reviewed pursuant to the provisions of Chapter 3 of this Manual.

1.8 Consideration of Proposals - Decision

The State Health Officer shall consider the Department's staff analysis on each proposal before making a decision. Such analysis shall be based on the proposal's consistency with the specifications and criteria established by the Department and its substantial compliance with the projection of need as reported in the State Health Plan in effect at the time the application for the proposal was submitted.

The decision of the State Health Officer shall be based on one of the following conditions:

1. The proposal is in substantial compliance with the required findings that are necessary for approval.

2. The proposal is not in substantial compliance with the necessary required findings for approval.

3. The proposal, with certain stipulated revisions, is in substantial compliance with the necessary findings for approval.

After reaching a decision regarding a proposal, the State Health Officer shall provide a written notification to the applicant, and others upon request, within (ten) 10 calendar days of the announcement of his or her decision.

1.9 Policy Regarding Public Access to Records and Data

The Department holds available for public inspection and copying those records made or received by the Department in connection with the performance of the Department's functions under its designation as the State Health Planning and Development Agency (SHPDA).

The following items are available:

1. The State Health Plan.

2. Contents of the files pertaining to Certificate of Need (CON) applications.

3. Published reports of the Health Planning and Resource Development Division.

4. Selected statistical data regarding health facilities utilization and health manpower.

1.10 Procedure for Requesting Information

Requests for copies of the State Health Plan or other published reports may be made by

telephone, by written request, or in person to the Health Planning and Resource Development Division.

Requests to review individual CON files must be made in writing. Requests for information contained in the CON application files must be made in writing and must state specifically what information is desired. These requests should be addressed to:

Public Records Liaison
Office of Communication, Osborne 100
Mississippi State Department of Health
P.O. Box 1700
Jackson, MS 39215-1700

In accordance with Section 25-61-5, Mississippi Code of 1972, Annotated, as amended, no open-ended requests will be honored. All requests for information contained in the CON files must stand alone.

Requests for statistical data must be made in writing and should describe the specific items requested as to nature of data, time frame requested, and whether statewide or specified counties.

If an applicant or their representative wishes to review their own CON file, they may do so at any time during regular business hours without first submitting a request in writing.

1.11 Processing of Requests

Requests for published reports will be filled no later than seven (7) business days following the receipt of such request.

If the Division is unable to produce the records requested by the seventh business day after the request is made, the Division will provide a written explanation to the person making the request stating that the record requested will be produced and specifying with particularity why the records cannot be produced within the seven-business day period. Unless there is mutual agreement of the parties, in no event shall the date for the Division's production of the requested records be any later than fourteen (14) business days from the receipt of the original request.

These time schedules represent projected maximum times. The Division will fulfill all requests as promptly as possible.

A CON application filed with the Department shall be available for inspection and copying only after said application has been deemed complete by Division staff.

Requests for specific statistical data will be processed in an expeditious manner, but no time guarantees can be made due to the availability of database programmers and staff's work priorities.

1.12 Index of Records

The index of CON files is maintained in the Health Planning and Resource Development Division of the Department.

1.13 Fees

Standard fees per copy are established for Public Records Requests. These fees have been calculated to cover the cost of paper, printing, binding and handling charges for each document. The price list for published reports and statistical data requests is available from the Division of Health Planning and Resource Development.

For information contained in the files of the Division, a fee of $0.20 per page for black and white copies, $0.50 per page for color copies and $0.50 per page for scanned copies. A minimum fee of $35.00 is charged for the administrative processing of all Public Records Request.

Advance payment is required for any information received from the Division of Health Planning and Resource Development.

1.14 Definition of Terms

a. **Affected Person** means:

1. the applicant;

2. a person residing within the geographic area served or to be served by the applicant's proposal;

3. a person who regularly uses health care facilities or Health Maintenance Organizations (HMO) located in the geographic area of the proposal which provide similar service to that which is proposed;

4. health care facilities and HMOs which, before receipt of the application under review, formally indicated an intention to provide services similar to that of the proposal being considered at a future date;

5. third party payors who reimburse health care facilities located in the geographical area of the proposal; or

6. any agency that establishes rates for health care services or HMOs located in the geographic area of the proposal.

b. **Aggrieved Party** includes the Mississippi Department of Health, the applicant, and any person who actively participated in the proceedings before the

Mississippi Department of Health. Active participation in the proceedings includes requesting a hearing during the course of review, and the timely filing of written comments which completely and formally set out objections to the application and the reasons for those objections.

c. **Applicant** means an individual, a partnership, a corporation (including associations, joint stock companies and insurance companies), a state or political subdivision or instrumentality (including a municipal corporation) of a state.

d. **Bed Capacity** means the number of beds by licensure category within the facility as determined by the Department's Health Facilities Licensure and Certification Division.

e. **By or On Behalf Of** means a capital expenditure by a health care facility which meets a review threshold, or a capital expenditure by another entity which will result in a direct or indirect benefit to a health care facility, including capital expenditures by parent corporations for the benefit of their health facility holdings and guarantor arrangements on loans and/or leases.

A capital expenditure "by or on behalf of a health care facility" includes but is not limited to the following:

1. Medical office building (MOB) or other structure is constructed on land adjacent to a health care facility;

2. Land is leased from a health care facility for the construction of a MOB or other structure to benefit the health care facility;

3. The health care facility has an option to purchase the MOB or other structure;

4. The health care facility maintains the authority to approve tenants of the MOB or other structure; and/or

5. The health care facility retains the option to assume control of the MOB or other structure and collect rent.

f. **Capital Expenditure**:

1. When pertaining to defined major medical equipment, shall mean an expenditure which, under generally accepted accounting principles consistently applied, is not properly chargeable as an expense of operation and maintenance and which exceeds one million five hundred thousand dollars ($1,500,000.00)

2. When pertaining to a clinical health service, other than major medical equipment shall mean any expenditure which, under generally accepted accounting principles consistently applied, is not properly chargeable as an

expense of operation and maintenance and which exceeds five million dollars ($5,000,000.00), adjusted for inflation by the State Department of Health. The Department will use the inflation index, as published by the State Economist annually, to calculate this adjustment. The Department will publish the new amounts each year on its website.

3. When pertaining to non-clinical health service, other than major medical equipment, shall mean any expenditure which, under generally accepted accounting principles consistently applied, is not properly chargeable as an expense of operation and maintenance and which exceeds ten million dollars ($10,000,000.00) adjusted for inflation by the State Department of Health. The Department will use the inflation index, as published by the State Economist annually, to calculate this adjustment. The Department will publish the new amounts each year on its website.

4. Shall include the acquisition, whether by lease, sufferance, gift, devise, legacy, settlement of a trust or other means, of any facility or part thereof, or equipment for a facility, the expenditure for which would have been considered a capital expenditure if acquired by purchase. Transactions which are separated in time but are planned to be undertaken within 12 months of each other and are components of an overall plan for meeting patient care objectives shall, for purposes of this definition, be viewed in their entirety without regard to their timing.

5. In those instances where a health care facility or other provider of health services proposes to provide a service in which the capital expenditure for major medical equipment or other than major medical equipment or a combination of the two may have been split between separate parties, the total capital expenditure required to provide the proposed service shall be considered in determining the necessity of CON review and in determining the appropriate CON review fee to be paid. The capital expenditure associated with facilities and equipment to provide services in Mississippi shall be considered regardless of where the capital expenditure was made, in state or out of state, and regardless of the domicile of the party making the capital expenditure, in state or out of state.

g. **Capital Lease** means a lease which meets one or more of the following conditions:

1. Title is transferred to the lessee by the end of the lease term.

2. The lease contains a bargain purchase option at less than the fair value at the time of the option.

3. The lease term is at least 75 percent of the leased property's estimated economic life.

4. The present value of the minimum lease payments is 90 percent or more of the fair value of the leased property.

Operating Leases do not meet any of the four criteria listed above.

h. **Certificate of Need** means a written order by the State Health Officer setting forth the affirmative finding that a proposal in prescribed application form sufficiently satisfies the plans, standards, and criteria prescribed for such service or other project by Sections 41-7-171 et seq., Mississippi Code of 1972 Annotated, as amended, and by rules and regulations promulgated thereunder by the Department.

i. **Change of Ownership** includes, but is not limited to, inter vivos gifts, purchases, transfers, lease arrangements, cash and/or stock transactions or other comparable arrangements whenever another person or entity (not the current owner) acquires or controls the majority interest of an existing health care facility, and/or the change of ownership of major medical equipment, a health service, or an institutional health service. Changes of ownership from partnerships, single proprietorships, or corporations to another form of ownership are specifically included. However, "Change of Ownership" shall not include any inherited interest acquired as a result of a testamentary instrument or under the laws of descent and distribution of the State of Mississippi.

j. **Change in Project Scope** is defined as any substantive change, as determined by the State Department of Health, in plans to construct or renovate a health care facility, in number of beds or services to be offered within the facility, or in capital expenditure authorized by the approved CON.

k. **Clinical Health Service** shall only include those activities which contemplate any change in the existing bed complement of any health care facility through the addition or conversion of any beds, under Section 41-7-191(1)(c) or propose to offer any health services if those services have not been provided on a regular basis by the proposed provider of such services within the period of twelve (12) months prior to the time such services would be offered, under Section 41-7- 191(1)(d).

l. **Construction** means the erection, building, or substantial alteration, reconstruction, improvement, renovation, extension, or modification of a health care facility and the studies, surveys, designs, plans, working drawings, specifications, procedures, and other actions necessary thereto.

m. **Commencement of Construction** means that all of the following have been completed with respect to a proposal or project proposing construction, renovation, remodeling, or alteration.

1. A legally binding written contract has been executed and consummated by the proponent and a lawfully licensed contractor to construct and/or

complete the intent of the proposal within a specified period of time in accordance with final architectural plans which have been approved by the licensing authority of the Department;

2. Any and all permits and/or approvals deemed lawfully necessary by all authorities with responsibility for such have been secured;

3. Actual bona fide undertaking of the subject proposal has commenced, and a progress payment of at least one percent of the total cost of the contract has been paid to the contractor by the proponent; and

4. Requirements of this paragraph have been met and certified in writing by the Department.

Force account expenditures, such as deposits, securities, bonds, et cetera, may, in the discretion of the Department, be excluded from any or all of the provisions of defined commencement of construction.

n. **Consumer** means an individual who is not a provider of health care or representative of a provider of health care services or who has no financial or indirect interest in any provider of services.

o. **Determination of Reviewability** means findings of the Department setting forth the Department's decision as to the requirement for certificate of need review regarding a proposal pending before it, pursuant to Section 41-7-205.

p. **Develop**, when used in connection with health services, means to undertake those activities which, on their completion, will result in the offering of a new institutional health service or the incurring of a financial obligation as defined under applicable state law in relation to the offering of such services.

q. **Health Care Facility** includes hospitals, long term care hospitals, psychiatric hospitals, chemical dependency hospitals, comprehensive medical rehabilitation facilities, skilled nursing facilities, intermediate care facilities, intermediate care facilities for the mentally retarded, psychiatric residential treatment facilities, pediatric skilled nursing facilities, end stage renal disease facilities (including freestanding hemodialysis units), ambulatory surgical facilities, and/or home health agencies (including facilities owned or operated by the State or political subdivision or instrumentality of the State) but does not include Christian Science sanatoriums operated or licensed and certified by the First Church of Christ, Scientist, Boston, Massachusetts. This definition shall not apply to facilities for the private practice, either independently or by incorporated medical groups, of physicians, dentists, or other health care professionals except where such facilities are an integral part of an institutional health service. The various health care facilities listed in this paragraph shall be defined as follows:

1. **Ambulatory Surgical Facility** means a facility primarily organized or established for the purpose of performing surgery for outpatients and is a

separate identifiable legal entity from any other health care facility. Such term does not include the offices of private physicians or dentists, whether for individual or group practice.

2. **Chemical Dependency Hospital** means an institution which is primarily engaged in providing to inpatients, by or under the supervision of a physician, medical and related services for the diagnosis and treatment of chemical dependency such as alcohol and drug abuse.

3. **Comprehensive Medical Rehabilitation Facility** means a hospital or a hospital unit that is licensed and/or certified as a comprehensive medical rehabilitation facility which provides specialized programs that are accredited by the Commission on Accreditation of Rehabilitation Facilities and supervised by a physician Board-certified or Board-eligible in psychiatry or other doctor of medicine or osteopathy with at least two years of training in the medical direction of a comprehensive rehabilitation program that:

    a. Includes evaluation and treatment of individuals with physical disabilities;

    b. Emphasizes education and training of individuals with disabilities;

    c. Incorporates at least the following core disciplines:

        i. Physical Therapy

        ii. Occupational Therapy

        iii. Speech and Language Therapy

        iv. Rehabilitation Nursing; and

    d. Incorporates at least three of the following disciplines:

        i. Psychology

        ii. Audiology

        iii. Respiratory Therapy

        iv. Therapeutic Recreation

        v. Orthotics

        vi. Prosthetics

        vii. Special Education

viii. Vocational Rehabilitation

ix. Psychotherapy

x. Social Work

xi. Rehabilitation Engineering

These specialized programs include, but are not limited to, spinal cord injury programs, head injury programs, and infant and early childhood development programs.

4. **End Stage Renal Disease (ESRD) Facilities** means kidney dialysis centers, which includes freestanding hemodialysis units and limited care facilities. The term "limited care facility" generally refers to an off-hospital-premises facility, regardless of whether it is provider or non-provider operated, which is engaged primarily in furnishing maintenance hemodialysis services to stabilized patients.

5. **Hospital** means an institution which is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic services and therapeutic services for medical diagnosis; treatment and care of injured, disabled, or sick persons; or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. Such term does not include psychiatric hospitals.

6. **Home Health Agency** means a public or privately owned agency or organization, or a subdivision of such an agency or organization, properly authorized to conduct business in Mississippi, which is primarily engaged in providing to individuals at the written direction of a licensed physician, in the individual's place of residence, skilled nursing services provided by or under the supervision of a registered nurse licensed to practice in Mississippi, and one or more of the following services or items:

a. Physical, occupational, or speech therapy;

b. Medical social services;

c. Part-time or intermittent services of a home health aide;

d. Other services as approved by the licensing agency for home health agencies;

e. Medical supplies, other than drugs and biological, and the use of medical appliances; or

f. Medical services provided by an intern or resident-in-training at a hospital under a teaching program of such hospital.

Further, all skilled nursing services and those services listed in items 1 through 4 of this paragraph (f) must be provided directly by the licensed home health agency. For purposes of this subparagraph, "directly" means either through an agency employee or by an arrangement with another individual not defined as a health care facility. This paragraph shall not apply to health care facilities which had contracts for the above services with a home health agency on January 1, 1990.

7. **Intermediate Care Facility** means an institution which provides, on a regular basis, health related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who, because of their mental or physical condition, require health related care and services (above the level of room and board).

NOTE: Under federal guidelines, nursing facilities are no longer licensed as intermediate care facilities. Effective October 1, 1990, nursing facilities are classified, based on reimbursement levels, as nursing facilities or skilled nursing facilities (see skilled nursing facility).

8. **Intermediate Care Facility for the Mentally Retarded** means an intermediate care facility that provides health or rehabilitative services in a planned program of activities to, persons with intellectual disability, also including but not limited to cerebral palsy and other conditions by the Federal Developmentally Disabled Assistance and Bill of Rights Act, Public Law 94-103.

9. **Long-Term Care Hospital** means a freestanding, Medicare-certified hospital that has an average length of inpatient stay greater than 25 calendar days, which is primarily engaged in providing chronic or long term medical care to patients who do not require more than three hours of rehabilitation or comprehensive rehabilitation per day, and has a transfer agreement with an acute care medical center and a comprehensive medical rehabilitation facility. Long term care hospitals shall not use rehabilitation, comprehensive medical rehabilitation, medical rehabilitation, sub-acute rehabilitation, nursing home, skilled nursing facility, or sub-acute care facility in association with its name.

10. **Pediatric Skilled Nursing Facility** means an institution or a distinct part of an institution that is primarily engaged in providing to inpatients skilled nursing care and related services for persons under 21 years of age who require medical or nursing care or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

11. **Psychiatric Hospital** means an institution which is primarily engaged in providing to inpatients, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of persons with mental illness.

12. **Psychiatric Residential Treatment Facility** means any non-hospital establishment with permanent licensed facilities which provides a twenty-four (24) hour program of care by qualified therapists including, but not limited to, duly licensed mental health professionals, psychiatrists, psychologists, psychotherapists and licensed certified social workers, for emotionally disturbed children and adolescents referred to such a facility by a court, local school district, or by the Department of Human Services, who are not in an acute phase of illness requiring the services of a psychiatric hospital, and are in need of such restorative treatment services. For purposes of this paragraph, the term "emotionally disturbed" means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance:

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

    b. An inability to build or maintain satisfactory relationships with peers and teachers;

    c. Inappropriate types of behavior or feelings under normal circumstances;

    d. A general pervasive mood of unhappiness or depression; or

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

13. **Rehabilitation Hospital** means a hospital or established and dedicated unit of a general hospital licensed for rehabilitation, which is organized, staffed, and equipped to render services toward the rehabilitation of disabled persons through an integrated program of medical, psychological, social, and vocational evaluation and provision of services over a continuous period exceeding 24 hours. The average length of stay for such beds shall be 30 calendar days or more.

14. **Skilled Nursing Facility (SNF)** means a health institution planned, organized, operated, and maintained to provide facilities and health services with related social care to inpatients who require medical care and 24-hour nursing services for illness, injury, or disability. Each patient shall be under the care of a physician licensed to practice medicine in the State of Mississippi. The nursing services shall be organized and

maintained to provide 24-hour nursing services under the direction of a registered professional nurse employed full-time.

r. **Health Maintenance Organization** or **"HMO"** means a public or private organization which:

1. Provides or otherwise makes available to enrolled participants health care services, including substantially the following basic health care services: usual health care services, hospitalization, laboratory, x-ray, emergency and preventive services, and out-of-area coverage;

2. Is compensated (except for co-payments) for the provision of the basic health care services listed in subparagraph (a) of this paragraph to enrolled participants on a predetermined basis; and

3. Provides health care services primarily:

   a. Directly through physicians who are either employees or partners of such organization; or

   b. Through arrangements with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis).

s. **Health Planning Area** means that geographic area specified in the State Health Plan that is determined by population data, patient origin data, and area health facilities offering referral services to the area. Health Planning Areas are used for determining bed need and/or service needs within the state.

t. **Health Service Area** means a geographic area of the state designated in the State Health Plan as the area to be used in planning for specified health facilities and services and to be used when considering CON applications to provide health facilities and service.

u. **Health Services** means clinically related (i.e., diagnostic, treatment, or rehabilitative) services and include alcohol, drug abuse, mental health, and home health care services

v. **Hospital and/or Health Facility Based** means a health service that is physically located in or legally owned by the hospital or health facility.

w. **Institutional Health Services** shall mean health services provided in or through health care facilities and shall include the entities in or through which such services are provided.

x. **Major Medical Equipment** means medical equipment costs in excess of one million five hundred thousand dollars ($1,500,000.00). However, this definition shall not be applicable to clinical laboratories if they are determined by the

Department to be independent of any physician's office, hospital, or other health facility or otherwise not so defined by federal or state law, or rules and regulations promulgated there under.

y. **Nonclinical Health Services** shall be all other health services, which do not involve any change in the existing bed complement or offering health services as described herein.

z. **Offer** means, when used in connection with health services, that the State Department of Health has determined that the health care facility is capable of providing specified health services.

aa. **Person** means an individual, a trust or estate, partnership, corporation (including associations, joint stock companies, and insurance companies), the State, or political subdivision or instrumentality of the State.

bb. **Provider** means any person who is a provider or representative of a provider of health care services requiring a CON or who has any financial or indirect interest in any provider or services.

cc. **Secretary** means the Secretary of Health and Human Services and any officer or employee of the Department of Health and Human Services to whom the authority involved has been delegated.

dd. **Similar Equipment** means pieces of equipment which are similar in function and appearance. For example, a manually operated bed and an electrically operated bed are similar units. A 1,000 power microscope and a 500 power microscope are similar units. A coulter counter and a microscope are not similar units.

ee. **State Health Plan** means the sole and official statewide health plan for Mississippi which identifies priority state health needs and establishes standards and criteria for health related activities which require Certificate of Need review in compliance with Section 41-7-191, Mississippi Code of 1972, as amended.

ff. **State Department of Health** shall mean the state agency created under Section 41-3-15, Mississippi Code of 1972 as amended, which shall be considered to be the State Health Planning and Development Agency, as defined in paragraph 1.46 below.

gg. **State Health Planning and Development Agency** means the agency of state government designated to perform health planning and resource development programs for the State of Mississippi.

hh. **Swing Bed Program** means the interchangeable utilization of hospital beds for the provision of acute or extended care with reimbursement based on the specific level of care provided.

CHAPTER 2 - SCOPE OF COVERAGE OF THE CON REVIEW PROGRAM

2.1 The State CON program applies to the obligation of capital expenditures, the establishment of new health care facilities, the offering of defined new institutional health services, clinical health services, and the acquisition of major medical equipment.

Within these parameters, no person shall engage in any of the following activities without obtaining a CON from the Department:

2.1.1 Any capital expenditure that exceeds the expenditure threshold. This capital expenditure includes the cost of any studies, surveys, designs, plans, working drawings, specification and other activities (including staff efforts and other services) associated with the capital expenditure and includes an acquisition for less than fair market value if the acquisition at fair market value would exceed the expenditure threshold.

A capital expenditure shall include the acquisition, whether by lease, sufferance, gift, devise, legacy, settlement of a trust or other means, of any facility or part thereof, or equipment for a facility, the expenditure for which would have been considered a capital expenditure if acquired by purchase. Transactions which are separated in time but are planned to be undertaken within 12 months of each other and are components of an overall plan for meeting patient care objectives shall, for purposes of this definition, be viewed in their entirety without regard to their timing.

In those instances where a health care facility or other provider of health services proposes to provide a service in which the capital expenditure for major medical equipment or other than major medical equipment or a combination of the two may have been split between separate parties, the total capital expenditure required to provide the proposed service shall be considered in determining the necessity of CON review and in determining the appropriate CON review fee to be paid. The capital expenditure associated with facilities and equipment to provide services in Mississippi shall be considered regardless of where the capital expenditure was made, in state or out of state, and regardless of the domicile of the party making the capital expenditure, in state or out of state.

NOTE: A capital expenditure is considered to be incurred: (a) when a contract enforceable under state law is entered into for the construction, acquisition, lease or financing of the capital asset or (b) when the governing board of a health care facility takes formal action to commit its own funds for a construction project under-taken by personnel of the health care facility (force account expenditure) or (c) in the case of donated property, on the date on which the gift is complete under applicable state law.

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

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

NOTE: The relocation of a health care facility is defined as the relocation of a health care facility from one physical location or site to another.

A portion of a health care facility is considered to be a wing, unit, service(s), or beds.

The relocation of major medical equipment shall include, but is not limited to, the relocation of major medical equipment from one physical facility to another physical facility.

2.1.4 Any change in the existing bed complement of any health care facility through the addition or conversion of any beds or the alteration, modernizing or refurbishing of any unit or department in which the beds may be located; however, if a health care facility has voluntarily de-licensed some of its existing bed complement, it may later relicense some or all of its de-licensed beds without the necessity of having to acquire a certificate of need. The State Department of Health shall maintain a record of the de-licensing health care facility and its voluntarily de-licensed beds and continue counting those beds as part of the state's total bed count for health care planning purposes. If a health care facility that has voluntarily de-licensed some of its beds later desires to relicense some or all of its voluntarily de-licensed beds, it shall notify the State Department of Health of its intent to increase the number of its licensed beds. The State Department of Health shall survey the health care facility within thirty (30) calendar days of that notice and, if appropriate, issue the health care facility a new license reflecting the new contingent of beds. However, in no event may a health care facility that has voluntarily de-licensed some of its beds be reissued a license to operate beds in excess of its bed count before the voluntary de-licensure of some of its beds without seeking certificate of need approval.

A healthcare facility seeking to place beds in abeyance (a state of voluntary temporary suspension/de-license) or re-license beds must submit a letter to the Mississippi State Department of Health – Division of Health Planning and Resource Development requesting that the beds be placed in abeyance (de-license) or removed from abeyance (re-licensed).

A fee of Five Hundred Dollars ($500.00) shall be assessed for the processing and handling of all abeyance requests and is payable to the Mississippi State Department of Health by check, draft, or money order.

2.1.5 Offering of the following health services if those services have not been provided on a regular basis by the proposed provider of such services within the period of 12 months

before the time such services will be offered: Open heart surgery services;

1. Open heart surgery services;

2. Cardiac catheterization services;

3. Comprehensive inpatient rehabilitation services;

4. Licensed psychiatric services;

5. Licensed chemical dependency services;

6. Radiation therapy services;

7. Diagnostic imaging services of an invasive nature, i.e., invasive digital angiography;

8. Nursing home care as defined in subparagraphs (iv) (skilled nursing facility), (vi) (intermediate care facility), and (vii) (intermediate care facility for the mentally retarded) of Section 41-7-173 (h);

9. Home health services;

10. Swing bed services;

11. Ambulatory surgical services;

12. Magnetic resonance imaging services;

13. Positron emission tomography services; and

14. Long term care hospital services.

2.1.6 The relocation of one or more health services from one physical facility or site to another, unless such relocation, which does not involve a capital expenditure by or on behalf of the health care facility, (i) is to a physical facility or site within five thousand two hundred eighty (5,280) feet from the main entrance of the health care facility where the health care service is located, or (ii) is the result of an order of a court of appropriate jurisdiction or a result of pending litigation in such courts, or by order of the State Department of Health, or by order of any other agency of legal entity of the State, the federal government, or any political subdivision of either, whose order is also approved by the Department.

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

2.1.8 Changes of ownership of existing health care facilities, major medical equipment, a health service, or an institutional health service, in which a notice of intent is not filed with the State Department of Health at least 15 calendar days before the date such change of ownership occurs.

2.1.9 Regardless of paragraph 2.1.8 above, the change of ownership of any skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded in which a notice of intent as described in 2.1.8 has not been filed and if the Executive Director, Division of Medicaid, Office of the Governor, has not certified in writing that there will be no increase in allowable costs to Medicaid from revaluation of the assets or from increased interest and depreciation as a result of the proposed change of ownership.

2.1.10 Any activity described in paragraphs 2.1.1 through 2.1.9, if undertaken by any person if that same activity would require CON approval if undertaken by a health care facility.

2.1.11 Any capital expenditure or deferred capital expenditure by or on behalf of a health care facility not covered by paragraphs 2.1.1 through 2.2.10.

NOTE: Examples of capital expenditures "by or on behalf of a health care facility" include, but are not limited to the following:

1. Medical office building (MOB) or other structure is constructed on land adjacent to a health care facility;

2. Land is leased from a health care facility for the construction of a MOB or other construction to benefit the health care facility;

3. The health care facility has an option to purchase the MOB or other structure;

4. The health care facility maintains the authority to approve tenants of the MOB or other structure; and/or

5. The health care facility retains the right to assume control of the MOB or other structure and collect rent.

2.1.12 The contracting of a health care facility as defined in subparagraphs (i) through (viii) of Section 41-7-173(h), Mississippi Code of 1972 Annotated, as amended to establish a home office, sub-unit, or branch office in the space operated as a health care facility through a formal arrangement with an existing health care facility as defined in subparagraph (ix) of Section 41-7-173(h).

2.2 Moratoria

Presently, the Department is prohibited from granting approval for or issuing Certificates of Need to any person proposing the new construction of, addition to, or expansion of any health care facility defined in subparagraphs (iv) (skilled nursing facility), (vi) (intermediate care facility), and (viii) (intermediate care facility for the mentally retarded) of Section 41-7-173 (h) or the conversion of vacant hospital beds to provide skilled or intermediate nursing home care, except as specifically authorized by statute.

The Department, likewise, is prohibited from granting approval for or issuing a CON to any person proposing the establishment or expansion of the currently approved territory of, or the contracting to establish a home office, subunit, or branch office within the space operated as a health care facility as defined in Section 41-7-173 (h) (i) through (viii) by a health care facility as defined in subparagraph (ix) (home health agency) of Section 41-7-173 (h).

The Department, however, is authorized to issue a license to an existing home health agency (HHA) for the transfer of a county from that agency to another existing HHA, and to charge a fee for reviewing and making a determination on the application for such transfer not to exceed one-half of the authorized fee assessed for the original application for the HHA (see 116.03).

2.3 Exemptions

2.3.1 Health care facilities owned and/or operated by the State or its agencies are exempt from the restraints in this section against issuance of a CON if such addition or expansion consists of repair or renovation necessary to comply with the state licensure law. This exception shall not apply to the new construction of any building by such state facility. This exception shall not apply to any health care facilities owned or operated by counties, municipalities, districts, unincorporated areas, other defined persons, or any combination thereof.

2.3.2 The new construction, renovation or expansion of or addition to any health care facility defined in subparagraph (ii) (psychiatric hospital), subparagraph (iv) (skilled nursing facility), subparagraph (vi) (intermediate care facility), subparagraph (viii) (intermediate care facility for the mentally retarded), and subparagraph (x) (psychiatric residential treatment facility) of Section 41-7-173 (h) which is owned by the State of Mississippi and under the direction and control of the State Department of Mental Health and the addition of new beds as the conversion of beds from one category to another in any such defined health care facility which is owned by the State of Mississippi and under the direction and control of the State Department of Mental Health shall not require the issuance of a CON under Section 41-7-171 et seq., notwithstanding any provision in Section 41-7-171 et seq. to the contrary.

2.3.3 The replacement or relocation of a health care facility designated as a critical access hospital shall be exempt from Section 41-7-191(1) so long as the critical access hospital complies with all applicable federal law and regulations regarding such replacement or relocation.

2.3.4 The new construction, renovation or expansion of or addition to any veterans home or domiciliary for eligible veterans of the State of Mississippi as authorized under Section 35-1-19 shall not require the issuance of a certificate of need, notwithstanding any provision in Section 41-7-171 et seq. to the contrary.

2.4 Swing-Bed Concept

The Department may issue a CON to any hospital to utilize a portion of its beds for the "swing-bed" concept. An eligible hospital must be in conformance with the federal

regulations regarding such swing-bed concept at the time it submits its application for a CON to the Department, except that such hospital may have more licensed beds or a higher average daily census (ADC) than the maximum number specified in federal regulations for participation in the swing-bed program.

A hospital meeting all federal requirements for participation in the swing-bed program that receives a CON shall render services provided under the swing-bed concept to any patient eligible for Medicare (Title XVIII of the Social Security Act) who is certified by a physician to be in need of such services, and no such hospital shall permit any patient who is eligible for both Medicaid and Medicare or eligible only for Medicaid to stay in the swing beds of the hospital for more than thirty (30) calendar days per admission unless the hospital receives prior approval for such patient from the Division of Medicaid, Office of the Governor.

Any hospital having more licensed beds or a higher average daily census (ADC) than the maximum number specified in federal regulations for participation in the swing-bed program which receives such CON shall develop a procedure to insure that before a patient is allowed to stay in the swing beds of the hospital no vacant nursing home bed for that patient is located within a 50-mile radius of the hospital.

When a hospital has a patient staying in the swing-beds of the hospital and the hospital receives notice from a nursing home located within a 50-mile radius that a vacant bed is available for that patient, the hospital shall transfer the patient to the nursing home within a reasonable time after receipt of the notice.

Any hospital which is subject to the requirements of the two preceding paragraphs may be suspended from participation in the swing-bed program for a reasonable period of time by the Department if the Department, after a hearing complying with due process, determines that the hospital has failed to comply with any of those requirements.

2.5 Dissemination of Scope of Coverage

The Department shall disseminate a description of the Scope of Coverage section before reviewing any project not previously within the scope of the State's program coverage. The scope of coverage shall be disseminated to all health care facilities and health maintenance organizations within the State and published in The Clarion-Ledger (Jackson, Mississippi) and other newspapers deemed appropriate. Whenever the scope of coverage is revised, the Department shall disseminate and publish a revised description of it.

CHAPTER 3 - CERTIFICATE OF NEED APPLICATION PROCEDURES

3.1 Notice of Intent To Apply for a Certificate of Need

A Notice of Intent outlines the general scope of a planned project requiring a CON shall be submitted to the Department as early as possible in the course of planning, but no later than fifteen (15) calendar days before any person files a CON application. The Notice of Intent shall be valid for a period of 180 calendar days (six months) from date of receipt.

The review of an application of any applicant who fails to submit the Notice of Intent to

Apply for a Certificate of Need at least fifteen (15) calendar days prior to the Application for a Certificate of Need shall be deferred until this fifteen (15) calendar day notice requirement is met. Under no circumstances shall an Application for a Certificate of Need be reviewed unless a Notice of Intent to Apply for a Certificate of Need has been filed first.

3.2 CON Application

Upon request by a potential applicant, the State Department of Health will provide the applicant with the appropriate CON kit, which contains criteria and standards for the requested service and application format to be used in preparation of the CON application. The applicant is required to answer fully and completely all questions that apply to the proposed project and to provide all enclosures required by the application format. Only that information which is prescribed by the format will be necessary. The Department may seek clarifying information to questions asked in the application format that were not fully answered.

3.3 Copy Requirements

An original and three copies of the completed application shall be provided to the Mississippi Department of Health, Health Planning and Resource Development Division, 570 E. Woodrow Wilson, Jackson, Mississippi 39215-1700.

3.4 Notice of Receipt of Application

A notice of receipt of application shall be timely published online on the Department's website.

3.5 Reviewing Applications for Completeness

Within fifteen (15) calendar days of receipt, each CON application shall be reviewed by the Department to determine that sufficient information required to conduct a review is contained in the application and that the CON processing fee, if applicable, has been paid. If these criteria are met, an application shall be deemed complete.

Note: A shell application that has numerous deficiencies at the time of original filing shall not be considered as an "incomplete application" in Section 3.6 herein below. A shell application is an application which, at the time of filling, lacks sufficient information to begin processing. **The Department will no longer accept shell applications.** Within fifteen (15) calendar days of receipt, a shell application will be returned to the submitter, along with the fee. The applicant may resubmit a completed application at any time.

3.6 Incomplete Applications

If the Department determines that an application is incomplete, the information required to render the application complete shall be requested of the applicant in writing within fifteen (15) calendar days of the application's filing. The request shall specify what additional information is required. Failure to provide the requested information within fifteen (15) calendar days will result in administrative withdrawal of the application unless

the applicant has requested the Department's review be deferred. Notice of such administrative withdrawal shall be furnished to the applicant and the administrative withdrawal or requested deferral shall be published on the Department's website. When an application is administratively withdrawn, the applicant is barred from proceeding with the project until a new application is submitted, deemed complete, reviewed, and a CON is issued by the Department.

3.7 Complete Applications

An application submitted by the proponent(s) of any proposal shall be logged in and shown as received on the business day of its receipt unless the Department is barred by law, rule, or regulation from accepting such application.

The Department shall determine if the application is complete according to its rules and regulations within the prescribed period of time as provided for in this Section of the ***CON Review Manual***.

If, after review has begun, additional clarifying information is requested, the applicant shall have fifteen (15) calendar days to submit the information, and, upon request of the applicant, the review period shall be extended fifteen (15) calendar days.

Until it is deemed complete, an applicant may submit additional material.

Members of the public, third-party payors, and all other affected persons may submit material to the Department at any time during the first fifteen (15) calendar days following the date the application is deemed complete.

Entry of an application into review shall cause timely notice to the public to be published on the Department's website that the application has been accepted by the Department and entered into review, and that the public is invited to comment on the application for a period of fifteen (15) calendar days from the deemed complete date, and the deadline date and time shall be clearly specified. Likewise, notice to the applicant shall be issued by mail, notifying recipients that the application has been accepted by the Department and entered into review.

3.8 Date of Issuance of Staff Analysis

The Department will not delay review of an application. The Department shall make its recommendation approving or disapproving an application within forty-five (45) calendar days of the date the application was filed or within fifteen (15) calendar days of receipt of any requested information, whichever is later.

3.9 State Health Officer's Decision

Unless a hearing is requested under Miss. Code Ann. § 41-7-197, the State Health Officer's final order approving or disapproving an application shall be issued within ninety (90) calendar days of the date the application was filed.

3.10 Emergency CON Review

Any health care facility, finding it a matter of immediate necessity to make a capital expenditure for replacement of or repair to equipment or facility caused by unforeseen or unpredictable events that may jeopardize the health and/or safety of the patients of such health care facility, may file an application for emergency CON. Emergency expenditures include those expenditures required for repair of fixed equipment to maintain the provision of quality care.

Such equipment includes, but is not limited to, heating and air conditioning equipment, elevators, electrical transformers and switch gear, sterilization equipment, emergency generators, water supply, and other utility connections.

Notification to the Department regarding an emergency capital expenditure shall be made in the following manner: the administrative executive officer (or one of his/her designated administrative assistants) of a health care facility in need of an emergency CON shall contact a member of the Department administrative staff who is responsible for the administration of the CON program. Justification for the emergency CON should be fully explained, describing in as much detail as possible the incurred loss or damage, the result or probable result of such loss or damage, the estimated cost or expenditure contemplated, the anticipated date such repairs or replacement will commence, the anticipated date of the completion of the repairs, and other necessary information requested by the staff member.

The State Health Officer, after obtaining required information, shall grant or deny the emergency Certificate of Need application. This decision will be communicated to the applicant as expeditiously as possible and the Department will timely give notice of such issuance to the public as with other applications.

Written notification shall be submitted as soon as possible by the applicant to the State Department of Health, explaining the nature of the emergency and other pertinent details regarding the request for the emergency CON.

If it is sufficiently documented that the alleged emergency did not exist, that there was an apparent intent to misrepresent facts, or that there was an apparent intent to perpetrate a fraud by the applicant, any such CON previously granted may be revoked or rescinded by the State Health Officer.

Emergency CONs shall be valid for not more than ninety (90) calendar days. Consequently, any recipient of an emergency CON is required to submit the appropriate CON application to the Department within fifteen (15) calendar days of the effective date of the emergency CON, addressing the same project for which the emergency CON was granted. Normal CON procedures are applicable to any subsequent application submitted by a recipient of an emergency CON with reference to the same project, except that there shall be no requirement for the filing of a Notice of Intent.

3.11 Certificate of Need Processing Fee

Per Miss. Code Ann. § 41-7-188, as may be amended from time to time, the amount of the processing fee to be assessed is determined by the following formula:

CON Fee = 0.50 x 1% of proposed capital expenditure

The minimum fee shall not be less than Five Thousand Dollars ($5,000) and the maximum fee shall not exceed Twenty-Five Thousand Dollars ($25,000.00).

Should the capital expenditure in the CON application differ from that in the notice of intent, the applicant must adjust the fee payment to conform to the fee stated in the CON application, being certain to capitalize only those increments of the total expenditure proposed which are appropriate.

Fee payment shall accompany the CON application and is payable to the Mississippi Department of Health by check, draft, or money order.

When a CON application is received by the Department, the capital expenditure will be determined, and the fee based on that amount. If the applicant has submitted overpayment of the CON fee as determined by the Department, the amount of the overpayment will be refunded. If partial payment of the CON fee has been submitted, the balance due must be received within fifteen (15) calendar days of receipt of partial payment due to the Department. The assessed CON fee, once paid, shall be non-refundable.

No application shall be deemed complete for the purpose of review until the required fee is received by the State Department of Health.

No filing fee shall be required for:

1. Any application submitted by an agency, department, institution, or facility which is operated, owned, and/or controlled by the State of Mississippi and which receives operating and/or capital expenditure funds solely by appropriations from the Legislature of the State; or
2. Any application submitted by a health care facility for repairs or renovation determined by the Health Facilities Licensure and Certification Division of the Department, in writing, to be necessary to avoid revocation of license and/or loss of certification for participation in the Medicaid and/or Medicare Programs. Any proposed expenditure in excess of the amount determined by the Department to be necessary to accomplish the stated purpose shall be subject to fee requirements previously detailed.

3.12 Notification to Affected Persons of CON Application Status

Notification to affected persons will be made on the day an application is deemed complete.

The notice to affected persons shall:

1. Give the date of entry into review;
2. Give the name and address of the applicant and the general description of the proposal;
3. Give the proposed schedule for review;
4. Give the period during which written comments on the project, either for or against, will be accepted by the Department (the dates when the public

comment period begins and ends);

5. Notify the affected party of the approximate date of publication of the staff analysis;

6. Give the method by which a copy of the staff analysis may be obtained; and

7. Notify the affected person that a hearing may not be requested until the staff analysis is published, and that any affected person may, within ten (10) calendar days of the date of publication of the staff analysis, request a hearing in accordance with the Department's rules and regulations, and the manner in which notification of any scheduled hearing will be made.

Notification to members of the public and third-party payors shall be provided by posting notices on the Department's website. Notification to the applicant shall be by mail. The date of notification is the date on which notice is mailed and posted on the Department's website.

3.13 Staff Analysis

Each application for a CON shall be assigned to a staff member of the Health Planning and Resource Development Division for analysis and review. The applications will be reviewed in compliance with the State Health Plan and the criteria contained in Chapter 8 of this manual. A written summary of the staff analysis and recommendation with respect to approval or disapproval shall be prepared. The staff analysis shall be made available online on the Department's website and shall be sent by United States Mail, postage pre-paid, to the applicant and to those who have filed a written request for the specific staff analysis in response to the notice to affected persons. If the staff is recommending disapproval, the applicant shall be allowed five (5) calendar days in which to provide additional material on its own application only for further analysis that may resolve the basis of the staff's recommendation of disapproval. Applicants will be notified of the deadline for the receipt for additional material. Any additional material presented by an applicant, not requested by the Department, and any additional material submitted by the applicant subsequent to the fifth (5^{th}) calendar day following the publication of a staff analysis recommending disapproval of the application shall not be considered at any time during the course of review.

NOTE: A one-time submission of new information in response to a negative staff analysis shall be submitted by the applicant only. No additional submissions will be accepted from the public.

Additional information shall be submitted directly to the Division of Health Planning and Resource Development.

The staff analysis and recommendation on any application on which a hearing during the course of review has been granted shall be prepared from information contained in the application at the time the hearing is requested, except for reports previously requested from other affected state agencies and information requested by Department staff. The staff analysis and recommendation shall be available online on the forty-fifth (45th) day

following the receipt of a complete application.

3.14 Determinations of Reviewability

An applicant proposing a project which may be governed by the provisions of Section 41-7-171 et seq., Mississippi Code Annotated, as amended, may submit a determination of reviewability request to obtain a written declaratory opinion regarding the reviewability of the proposed project. If such opinion is sought, the requestor and Department shall abide by the provisions of Miss. Code Ann. § 25-43-2.103 as they were effective on July, 2016, except that the Department's response shall be provided within forty-five (45) calendar days of the request.

Applicants proposing certification as a Single Specialty Ambulatory Surgery Center, or a Distinct Part SNF, Geropsychiatric DPU must contact the Department for a written opinion regarding the Reviewability of the service.

3.15 Notification of Filing of Determination of Reviewability

When a determination request is received, notification to affected persons will be made within five (5) business days of receipt of the request by publishing the notice on the Department's website.

3.16 Determination of Reviewability Processing Fee

Per Miss. Code Ann. § 41-7-205~~,~~ a fee payment of Two Thousand and Five Hundred Dollars ($2,500) shall accompany the application for Determination of Reviewability and is payable to the Mississippi Department of Health by check, draft, or money order.

3.17 Changes of Ownership

Prospective applicants proposing a change of ownership of existing health care facilities, and/or the change of ownership of a health service, major medical equipment, or an institutional health service must file a completed Notice of Intent to Change Ownership.

3.18 Change of Ownership Processing Fee

A fee payment of Two Thousand and Five Hundred Dollars ($2,500) shall accompany the application for any Notice of Intent Change of Ownership and is payable to the Mississippi State Department of Health by check, draft, or money order.

3.19 Transfer of County of Home Health Agency (HHA)

The Department, is authorized to issue a license to an existing home health agency (HHA) for the transfer of a county from that agency to another existing HHA, and to charge a fee for reviewing and making a determination on the application for such transfer not to exceed one-half of the authorized fee assessed for the original application for the HHA.

The amount of the fee to be assessed on transfer of a county from one agency to another shall be calculated as follows:

0.25 of 1% of the capital expenditure stated in the notice of transfer. The fee shall not be greater than Twelve Thousand Five Hundred Dollars ($12,500.00) and not less than Two Thousand and Five Hundred Dollars ($2,500).

The Transfer of Home Health Agency (HHA) County form must be filed with the Department thirty (30) calendar days prior to the transition. During the 30-day period it will be presented to the State Health Officer for a final decision.

If the Department denies the request to transfer county of a home health agency, then the Department will notify the applicant and follow the same procedures as denial of a six-month extension request.

CHAPTER 4 - PUBLIC HEARING DURING THE COURSE OF REVIEW

4.1 Hearing Request

Any affected person may, within ten (10) calendar days of publication of the staff analysis, request a public hearing during the course of review. An applicant, however, may request a hearing on its own application only if the staff recommendation is for disapproval of the application. Requests for a hearing in the course of review must be received by the Department not later than the close of business (5:00 p.m.) on the tenth (10th) calendar day after the date the staff analysis is published. Should the tenth (10th) calendar day fall on a Saturday, Sunday, or other legal holiday when the Department is actually closed for business, the request must be received by the Department by 5:00 p.m. on the next business day. If a public hearing is requested, appropriate notice shall be provided to the applicant and other affected persons. The general public to be served by the proposal shall be notified of such action by the Department through means of publication on the Department's website. Other public information channels may be utilized.

If no request for a hearing in the course of review is received, the State Health Officer may take action on the application.

If requested, a public hearing shall be commenced by an independent hearing officer designated by the Department within sixty (60) calendar days of the filing of the hearing request unless all parties to the hearing agree to extend the time for commencement of the hearing. Notification of the time, date, and place of the hearing will be given to all affected parties and the public in accordance with these regulations no later than fifteen (15) calendar days before such hearing.

The Department shall designate an independent hearing officer who shall not be an employee of the Department but who shall be a licensed attorney. In the hearing, any affected person shall have the right to be represented by counsel, to present oral or written arguments and evidence relevant to the matter, which is subject to the hearing, and to conduct reasonable questioning of persons who make relevant factual allegations (if the person is affected by the matter). A record of the hearing shall be made, and shall consist of a transcript of all testimony received, all documents and other material introduced by any interested person, the staff report and recommendation, and such other material as the Hearing Officer considers relevant, including his/her own recommendation, which he/she

shall make after the hearing is closed and after he/she has had an opportunity to review, study, and analyze the evidence presented during the hearing. Said recommendation shall be issued no later than forty-five (45) calendar days after the hearing is closed.

A copy of the Hearing Officer's report shall be sent to the parties to the hearing prior to the decision being announced by the State Health Officer.

4.2 Fee for Public Hearing

The fee assessed to cover the cost of conducting a public hearing during the course of review shall be an amount equal to $3,000 per day for each day of the hearing and shall be secured by a deposit of, $6,000 payable by the requestor, or shared equally by all requestors, at the time the request for hearing is received by the Department of Health. A request for hearing and payment of the fee and deposit must both be received within ten (10) calendar days of notice. The $6,000 fee will cover the cost of a hearing for a two-day period ONLY. Whenever a hearing exceeds the two-day period allotted, an additional fee of $3,000 per day for each day beyond the first two days shall be assessed to the requestor, or shared equally by all requestors, of said hearing. If the fees collected for a hearing exceed the actual costs, the remaining funds shall be refunded to the requestor(s) once all invoices have been paid. In the case of multiple requestors, the remaining funds will be divided equally between the parties. If the fees collected for a hearing are insufficient to cover the actual reasonable costs of the hearing, the requestor(s) shall be responsible for remitting additional fees to cover the costs.

Should the request for hearing be withdrawn, a portion of the assessed fee shall be refunded. A minimum of $1,000 will be retained by the Department. Any extraordinary expenses incurred, such as extra publication expenses, expenses of hiring a court reporter, extraordinary administrative time, etc., shall be deducted at a reasonable rate, and the remaining portion thereof shall be refunded to the person(s) requesting the hearing during the course of review.

Refund of fees will be made in accordance to the following regulations:

1. Portions of the $6,000 fee required to request a hearing during the course of a review will be refunded under the following circumstances:

a. When an application for a Certificate of Need is withdrawn by the applicant and a hearing during the course of review is pending but has not commenced at the time of the withdrawal of the application.

b. When the person or entity requesting the hearing during the course of review withdraws said request.

2. To obtain a partial refund of the hearing fee when the application has been withdrawn prior to commencement of the hearing, the requestor(s) must request said refund within five (5) business days after said application has been withdrawn.

The actions outlined in paragraph (1)(b), above, must have been completed

no later than five (5) business days before the day on which the hearing during the course of review was scheduled to be held. Any notice of the actions outlined in paragraph (1)(b), above, received later than five (5) business days prior to the date set for the hearing during the course of review will not entitle the requestor to a return of any portion of the fee paid.

3. When an application is administratively withdrawn by the Department prior to the commencement of the hearing, a full refund of filing fee will be made to the requestor(s).

4.3 Consolidation of Hearings

When applications involving a common question of law or fact or multiple proceedings involving the same or related parties are pending before a hearing officer, on the motion of any party, the Department, or the hearing officer's own motion, the hearing officer may order a joint hearing on any or all of the matters and issues in the cases. Additionally, the hearing officer may order any or all of the cases consolidated, and may make such other orders concerning proceedings therein as may tend to avoid unnecessary cost or delay.

4.4 Motions (Hearing in Course of Review)

Motions may be heard at any time subsequent to the receipt of a valid request for hearing by the Department, at a time and date to be selected at the discretion of the hearing officer. Motions which may be heard by the hearing officer shall normally include, but are not necessarily limited to:

1. Motion to strike or dismiss an application or request for hearing for failure of the application, applicant or requestor to follow the published rules and regulations of the Department;

2. Motion to set a hearing date;

3. Motion for issuance of subpoena(s);

4. Motion to compel discovery;

5. Motion to designate record;

6. Motion to quash or motion in limine;

7. Motion to impose sanctions.

To the extent practicable, except for motions to quash subpoenas, motions in limine, motions for protective order and other evidentiary motions, all pretrial motions shall be noticed for and shall be heard upon a date no less than ten (10) calendar days prior to the hearing during the course of review. Motions to quash subpoenas, motions in limine, motions for protective order and other evidentiary motions shall be noticed for and shall be heard upon a date no less than twenty (20) calendar days prior to the hearing during the course of review. Motions and the notices thereon shall be served in accordance with the rules of the Department governing service.

Except for good cause shown, no motion shall be served on opposing parties less than three (3) business days prior to the date of the scheduled motion hearing.

Opposing parties may, before the time specified herein for the hearing of the motion, serve upon the Hearing Officer and all other parties a written response to the motion.

At least ten (10) business days prior to the hearing during the course of review, the Hearing Officer shall conduct a hearing on any motion(s) filed herein. Although clearly interlocutory in nature for purposes of perfecting an appeal to Chancery Court, the Hearing Officer's ruling on the motion is final as to all matters regarding the conduct of the hearing. Any decision as to the disposition of a motion, whether made orally or in writing, will be entered into the record by the Hearing Officer.

4.5 Ex Parte Contacts

4.5.1 After the publication of a particular staff analysis, and before a written decision is made by the State Health Officer, there shall be no ex parte contacts between (a) any person acting on behalf of the applicant or holder of the CON or any person opposed to the issuance or in favor of the withdrawal of the CON and (b) the State Health Officer; the Chief of Staff; the Director of the Office of Health Policy and Planning; the hearing officer; or the staff of Health Planning and Resource Development. The prohibition against ex parte contacts shall not be construed to prohibit contact by and between staff members, a hearing officer, the Director of the Office of Health Policy and Planning, the Chief of Staff, the State Health Officer, and the staff of the Mississippi Attorney General's Office

4.5.2 Violation of Miss. Code Ann. §§ 41-7-171 through 41-7-209, or any rules or regulations promulgated in furtherance thereof by intent, fraud, deceit, unlawful design, willful and/or deliberate misrepresentation, or by careless, negligent or incautious disregard for such statutes or rules and regulations, either by persons acting individually or in concert with others, shall constitute a misdemeanor and shall be punishable by a fine not to exceed $1,000 for each such offense. Each day of continuing violation shall be considered a separate offense. The venue for prosecution of any such violation shall be in the county of the state wherein any such violation, or portion thereof, occurred.

4.6 Notification of the Status of Review

The State Department of Health, upon request of persons subject to review, shall provide timely notification of the status of review, the Department's findings, and other appropriate information respecting the review.

4.7 Limited Exchange of Information (Discovery)

In an effort to expedite the hearing process, parties to a hearing during the course of review shall exchange in writing the following information on or before the fortieth (40th) calendar day prior to the first date of the hearing:

1. A list of proposed issues that the parties reasonably believe shall be the

subject of the hearing;

2. A list of witnesses that shall include a full name, address and telephone number of every witness the parties reasonably anticipate calling at the hearing, together with whether the witness is a fact or expert witness, and a brief summary of the matters upon which the witness is expected to testify;

3. A true and correct copy of every document anticipated to be introduced at the hearing (except those documents introduced solely for rebuttal);

4. Copies of the underlying documentation which support the admissibility of charts, graphs, compilations, professional and expert reports (except where privileged) shall be produced for inspection if reasonable and exchanged if reasonably necessary;

5. A true and correct copy of every subpoena which the parties have or will request be issued to non-parties; (documents received by a party from non-parties in response to subpoenas must be furnished to all other parties no later than twenty (20) calendar days prior to the hearing).

6. All documents should be pre-marked for admission into evidence.

The parties are under a continuing duty to supplement this limited exchange of information and documents. All information and documents called for in this section should be finally supplemented by the parties no later than the twentieth (20th) calendar day prior to the first day of the hearing during the course of review.

4.8 Pre-Hearing Orders

On or before the twentieth (20th) calendar day prior to the first day of the hearing, the parties should exchange proposed pre-trial orders. The pre-trial order shall be in form generally accepted in the civil courts of Mississippi. The pre-trial order shall be agreed upon by the parties and entered by the hearing officer on or before the tenth (10th) calendar day prior to the hearing. If agreement cannot be reached by and between the parties to a hearing, the hearing officer shall resolve the disagreement and adjudicate a pre-trial order for entry on or before the tenth (10^{th}) calendar day prior to the hearing. Any hearing necessitated by disagreement between the parties or otherwise whose subject is the pre-trial order shall be noticed by the parties for a date on or before the tenth (10th) calendar day prior to the first day of the hearing during the course of review.

The pre-trial order shall include the order of proof, if applicable, a list of witnesses for each party, a statement that the parties have reached agreement as to the documents which have been pre-marked for admission, and that there is no question as to their authenticity and admissibility; a brief list and summation of the issues to be tried, an iteration of any stipulations reached; and any other matters upon which the parties may reach agreement, or which the hearing officer may require, in his/her discretion. The order shall contain a stipulation of any documents necessary to a determination of the hearing which were received or generated by the Department subsequent to the publication of the staff analysis, which, together with the application, documents received

subsequent to the application and prior to the staff analysis, and the staff analysis, will constitute the file of the Department for introduction into the record.

An executed copy of the pre-trial order shall be furnished to the hearing officer and to the Department for inclusion in the file.

4.9 Sanctions

Upon the motion of any party to a hearing, a hearing officer may impose reasonable sanctions on parties who fail or refuse to comply with the rules and regulations of the Department regarding certificates of need or who violate a hearing officer's order.
Additional reasonable sanctions may be imposed upon parties or non-parties who fail or refuse to comply with subpoenas. Reasonable sanctions include, but are not limited to, denial of or exclusion of information or documents sought; exclusion from the record of testimony of witnesses; or other reasonable measures. The imposition of sanctions shall not be to punish, but rather to compel fairness and to deny parties any advantage which might be gained by non-compliance.

4.10 Service of Documents

One copy of each document such as pleadings, motions, briefs, letters, etc., shall be served on each attorney of record in a particular matter. A copy shall likewise be served on the hearing officer, and one copy furnished to the Department for inclusion in the file. Any document furnished the Department for filing shall plainly state, on its face or in an accompanying letter, that it is being furnished for and is requested to be filed.

4.11 Furnishing Copies

Any document sought to be introduced into the record shall be accompanied by sufficient copies for all other counsel, including counsel opposite, the hearing officer and the court reporter.

Any motion or other pleading filed which references or is in response to another document previously filed shall be accompanied by a copy of the previously filed document (i.e., a motion to quash a subpoena shall be accompanied by a copy of the subpoena; a motion in limine to exclude a document shall be accompanied by a copy of the document).

4.12 Hearing Officer's Authority to Grant Subpoenas

The Mississippi State Board of Health, pursuant to its rule-making authority and subpoena powers granted unto it in Mississippi Code of 1972 Annotated, §§ 41-3-17 and 41-3-15(4)(1), respectively, hereby adopts the following rules:

The State Health Officer, vested with the authority of the board as described in § 41-3-5, Mississippi Code of 1972 Annotated, as amended will, at his/her discretion, appoint a Hearing Officer to hear any matter before the Mississippi Department of Health. The Hearing Officer shall be granted the authority to issue subpoenas to compel the

attendance of witnesses and the production of relevant documents and things. Any duly appointed Hearing Officer so authorized may issue a subpoena sua sponte, or upon application by any party to a matter being heard before the Mississippi Department of Health.

Except for good cause shown, no subpoena shall be issued less than thirty-five (35) calendar days and served less than thirty (30) calendar days, prior to the date of the hearing for which the subpoena is sought. Any subpoena duces tecum issued under this rule shall specify a date, time and place for the production of documents or things. The date for production shall be no less than twenty (20) calendar days prior to the date of the hearing, unless the subpoena is issued pursuant to a specific order of the hearing officer, which order may provide for another date. Upon issuance of a subpoena, the Hearing Officer may designate an individual employed by the Mississippi Department of Health or some other suitable person, such as the party requesting the subpoena, to execute and return service of the subpoena. The person to whom the subpoena is directed may, no less than twenty-five (25) calendar days before the date set as the first day of the hearing, serve upon the parties to the hearing and the Hearing Officer written objection to the subject matter of the subpoena together with a notice of a motion on the objection, in which case the attendance of the witness or the production of documents and things shall not be compelled except pursuant to an order by the Hearing Officer subsequent to the hearing on the motion. In considering the objection of a party to the issuance of a subpoena for the attendance of witnesses or the production of documents and things, the Hearing Officer shall consider the relevancy, probativeness, and reasonableness of the subject of the subpoena.

At least twenty (20) calendar days prior to the hearing, the Hearing Officer hears motions concerning the issued subpoenas, if any. The Hearing Officer's rulings on the issuing and disposition of the subpoenas are final as to all matters involving subpoenas issued or sought to be issued. Any such ruling, whether made orally or in writing, will be entered into the record by the Hearing Officer.

If any party subpoenaed under this rule shall refuse to comply with such subpoena, the Hearing Officer shall be authorized to certify such facts and enter same into the record. At that point, any party to the hearing may then move the appropriate court for relief during the hearing, but the hearing will not be delayed while this matter is being resolved.

4.13 Procedures For Conducting A "Hearing During The Course of Review"

4.13.1 Procedure and Other Related Matters (signing in)

Certificate of need hearings are open and public, except for rare occasions when the hearing officer may wish to inspect documents or examine witnesses in camera. To expedite the conduct of the hearing, persons attending should "sign in," listing their name, address and organization.

4.13.2 Declaration of Hearing Officer

The Hearing Officer opens the hearing (giving time and date).

The Hearing Officer will identify himself/herself and those responsible for recording the hearing.

The Hearing Officer has the authority to administer oaths, and will swear in those who wish to testify except officers of the courts, who are not required to be sworn.

The legal notice will be admitted into the record as Exhibit One by the Hearing Officer.

The file of the Department with respect to the application will be admitted into the record as Exhibit Two by the Hearing Officer.

The staff analysis with respect to the application will be admitted into the record as Exhibit Three by the Hearing Officer.

The Hearing Officer will read the following notice to those present: "This hearing is being conducted to discuss the merits of the application under consideration; please refrain from discussing or offering evidence concerning any other pending or yet-to-be-offered application that is not relevant to the matter in issue."

"Any affected person, during the conduct of the hearing, shall have the right to be represented by counsel. Additionally, any person may present oral or written arguments and evidence relevant to the matter which is subject to the Hearing and may conduct reasonable questioning of persons who make relevant, factual allegations if the person is affected by the matter."

4.13.3 Order of Proof

NOTE: All persons giving testimony during the conduct of the hearing will state their name and their organizational affiliation.

1. A member of the staff, who may give a brief summary of the Department's staff report; such staff member may be questioned by any affected person present, including the Hearing Officer.

2. The applicant.

3. The opponent(s), if any, in an order to be established by agreement between the opponent(s), or if no agreement can be reached, by the Hearing Officer. If no opponent(s) are present, the Department may present witnesses, exhibits, and testimony regarding the application, conduct questioning of witnesses presented by the Applicant, make objections, argue, and submit proposed findings of fact and conclusions of law and/or a proposed recommendation. In this instance, the Department should be represented by a staff attorney who may be an employee of the Mississippi Attorney General.

4. Persons who wish to give evidence for themselves or on behalf of a group or organization.

5. Persons who wish to give evidence but are not listed on "Sign-In" sheet and who have not been sworn (These persons will be sworn prior to giving testimony).

6. Rebuttal by the applicant, limited to matters raised during the opponent's case in chief.

7. Closing statements or arguments of counsel or affected persons. Waiver of the submission of closing statements or arguments at the hearing shall not entitle any party or affected person to argument before the State Health Officer. (Argument shall normally be by briefs, submitted to the Hearing Officer simultaneously, within thirty (30) calendar days of the close of the Hearing).

8. The Hearing Officer will then close the Hearing.

4.13.4 Submission of Written Documents

All exhibits, documents, written arguments, letters, photographs, etc., to be entered into the record (transcript) shall be on paper of not less than 8 1/2" x 11". Such, if not the required size, may be reproduced to 8 1/2" x 11" by photocopy or may be firmly affixed to paper of the required size by clear scotch-type tape.

Undeveloped film, disks and diskettes on which data or other information is stored, transparencies, documents or letters, or exhibits which are of poor quality and not easily read or understood (because of poor quality) shall not be permitted to be introduced into the Record (transcript). Such documentary evidence or written arguments as set out above shall be permitted into the Record (transcript) if of good quality, easily readable or understood (because of good quality and of the proper dimension) by the Hearing Officer.

Each page of any submission shall have a blank margin of not less than one inch at the top and the bottom, a blank margin on the left side of the page of not less than one-and-one-half inch, and a blank margin of not less than one-half inch on the right side of each page (Left and right are as the viewer looks at the page).

Any exhibit which is to be inserted in the transcript shall consist of not more than five pages - all properly numbered sequentially and also numbered Page 1, Page 2, etc., of that particular exhibit. All exhibits of more volume than five pages shall be considered as "bulky" exhibits.

The Hearing Officer, within his/her discretion, may hold the hearing open for a specified period of time for the submission of argument, briefs, or certain documentary evidence that he/she may request. Copies of any such material requested shall be furnished by the person or party of whom it was requested to the Hearing Officer, the Department, the CON applicant, and to the opposing parties. No further arguments, briefs, rebuttals,

presentations, or submission of other documentary material by any person or organization of any kind pertaining to any matter will be accepted.

Any witness during the course of a hearing may be cross-examined by any party to the hearing. The Department may question or cross-examine any witness through its attorney. The Hearing Officer may question any witness on direct or cross-examination.

4.13.5 Counsel Pro Hac Vice

Any attorney, appearing as such, representing any person or organization shall be in compliance with Rule 46(b) of the Mississippi Appellate Procedure Rules as to the appearance of counsel pro hac vice.

4.13.6 Procedures for Conducting Comparative "Hearing During the Course of Review"

The conduct of a comparative hearing during the course of review shall differ from a non-comparative hearing only in the following respects, and shall include all other procedures for conducting a non-comparative "hearing during the course of review":

4.13.6.1 Order of Proof

NOTE: All persons giving testimony during the conduct of the hearing will state their name and their organizational affiliation.

1. A member of the staff, who may give a brief summary of the Department's staff report; such staff member may be questioned by any affected person present, including the Hearing Officer.

2. The applicants, in the order that their requests for hearing were received by the Department.

3. The opponent(s), if any, in the order to be established by agreement between the opponent(s), or if no agreement can be reached, by the Hearing Officer. If no opponent(s) are present, the Department may present witnesses, exhibits, and testimony regarding the application, conduct questioning of witnesses presented by the Applicant, make objections, argue, and submit proposed findings of fact and conclusions of law and/or a proposed recommendation. In this instance, the Department should be represented by a staff attorney who may be an employee of the Mississippi Attorney General.

4. Rebuttal proof by the applicants, in the order in which they presented their cases in chief;

5. Persons who wish to give evidence for themselves or on behalf of a group or organization.

6. Persons who wish to give evidence but are not listed on "Sign-In" sheet and who have not been sworn (These persons will be sworn prior to giving testimony).

7. Closing statements or arguments of counsel or affected persons. Waiver of the submission of closing statements or arguments at the hearing shall not entitle any party or affected person to argument before the State Health Officer. (Argument shall normally be by briefs, submitted to the Hearing Officer simultaneously, within thirty (30) calendar days from the close of the Hearing).

8. The Hearing Officer will then close the Hearing.

CHAPTER 5 - FINDINGS AND ORDERS OF THE DEPARTMENT

5.1 Written Findings

The basis for CON decisions will be provided in writing. The Department may approve or disapprove a proposal for CON as originally presented in final form, or it may approve a CON by modification, by reduction only, of such proposal provided the proponent agrees in writing to such modification.

5.2 Decision and Final Order

The State Health Officer will review all applications to determine whether the proposed project substantially complies with plans, standards, and criteria prescribed for such projects by the governing legislation, by the State Health Plan, and the adopted rules and regulations of the Department. When a hearing during the course of review has been held, the completed record shall be certified to the State Health Officer, who shall consider only the record in making his/her decision; he/she shall not consider any evidence or material which is not included therein. The State Health Officer shall make his/her written findings and issue his/her orders after reviewing said records.

If the staff recommendation is to approve the project and the State Health Officer does not concur, the applicant shall have one opportunity only to submit additional information for staff analysis, and the State Health Officer shall delay his/her decision on the project until evaluation of the additional information is completed. Any additional information submitted must be received by the Department within fifteen (15) calendar days of the date the applicant is notified. The procedures to be followed at the subsequent review shall be the same as when the State Health Officer reviews a proposal for which a hearing during the course of review has not been held.

Whether or not a hearing during the course of review was held, the Department will post on its website the date in which the State Health Officer will make her decision.

If the State Health Officer finds that the project does conform to the applicable requirements, a decision to approve shall be rendered. If the State Health Officer finds that the project fails to satisfy the plans, standards, and criteria, a decision to disapprove will

be rendered. The State Health Officer's decision to approve or deny the Certificate of Need shall be the final order of the Department and shall be published on the Department's website and followed by written notice to the applicant. Any party aggrieved by any final order by the Department shall have the right of appeal to the Chancery Court of the First Judicial District of Hinds County, Mississippi, as provided by Section 41-7-201 Mississippi Code of 1972 Annotated, as amended (Supplement 1993), provided however, that any appeal of an Order disapproving an application for CON may be made to the Chancery Court of the county where the proposed construction expansion or alteration was to have been located or the new service or purpose of the capital expenditure was to have been utilized.

5.3 Designation of Record on Appeal

In order to allow the Department to adequately prepare the record for appeal, any party filing an appeal, cross-appeal, or other responsive pleading to a notice of appeal shall specifically designate the record for purposes of appeal, in fashion similar to that required by the Mississippi Rules of Appellate Procedure. Such designation must specifically set out any documents received or generated by the Department subsequent to the publication of the staff analysis that the party desires to be included in the appellate record.

5.4 Administrative Decisions

The State Health Officer may approve emergency CON's and six-month extensions without providing prior notice to affected persons or the public or providing an opportunity for a hearing during the course of review. These applications are described in Subsequent Reviews, in Chapter 6 of this manual.

5.5 Withdrawal of a Certificate of Need

Section 41-7-195, Mississippi Code of 1972 Annotated, as amended, states in part, "If commencement of construction or other preparation is not substantially undertaken during a valid Certificate of Need period or the State Department of Health determines that the applicant is not making a good faith effort to obligate such approved expenditure, the State Department of Health shall have the right to withdraw, revoke, or rescind the Certificate."

In considering the withdrawal, revocation, or rescission of the CON in those cases where an applicant has failed to show good faith effort through substantial progress, the Department shall take the following actions:

1. The applicant, affected persons, and the general public will be notified by appropriate means that withdrawal of the CON is under consideration by the Department and the reasons therefore;

2. Applicant so advised of contemplated action shall have thirty (30) calendar days from the date of the written notice to respond, and if they so desire, to request a public hearing before the State Health Officer or his/her independent designated hearing officer. If no response is received from the applicant during the 30-day period, the Department may conclude that the applicant concurs with the proposed action to withdraw, revoke or rescind the CON;

3. If a public hearing is requested by any affected party, the Department will conduct the hearing within forty-five (45) calendar days of receipt of the written request. The State Health Officer will render his/her written decision within thirty (30) calendar days following conclusion of any hearing on withdrawal of the Certificate of Need. Written notice of the date, time, and place of any hearing to be conducted on withdrawal of CON will be provided to affected persons at least five (5) calendar days before the date of the hearing and will be published in The Clarion-Ledger and/or other newspaper of general circulation in the area in which the project was to have been developed, if deemed appropriate by the Department.

Action taken by the Department to revoke, withdraw, or rescind a CON shall be in the form of a final written order. The same appeal rights that apply to initial review of the applications apply in the case of hearings or reviews to withdraw existing CON.

In the withdrawal of a Certificate of Need, the State Department of Health shall follow required procedures for notification of the beginning of the review; written findings and conditions; notification of the status of review; public hearing in the course of review; ex parte contact; judicial review; and annual reports of the State Department of Health.

CHAPTER 6 - SUBSEQUENT REVIEWS

6.1 Change in Scope of Approved Project

Applicants for a CON should clearly understand that if an approved project is changed substantially in scope - in construction, services, or capital expenditure the existing CON is void, and a new CON application is required before the proponent can lawfully proceed further.

6.2 Progress Reports

The CON holder is required to submit a written progress report every six months, or as requested by the department, and a final report upon completion of a project. For purposes of this chapter, completion shall mean when the approved proposed project is sufficiently complete so that it becomes operational for the purpose for which the certificate of need was issued. For projects that are incomplete, the CON holder is required to submit a six-month extension request thirty (30) calendar days prior to the expiration of the CON or any extended period (see Section regarding Six-Month Extension). The CON Holder shall certify the report and submit documentation of the CON holder's good faith effort to implement the CON by showing substantial progress.

A fee of One Thousand Dollars ($1,000) shall be assessed for the processing and handling of six-month extension- progress reports and six-month extension- final reports and is payable to the Mississippi State Department of Health by check, draft, or money order.

6.3 Six Month Extension

Certificates of Need are valid for a period not to exceed one year and may be extended by

the Department for an additional period not to exceed six months. In order to continue authority for a CON under a valid CON period following the initial twelve (12) month issuance period, the CON holder is required to document substantial progress toward completion of the CON and be granted a six-month extension.

If the CON project is incomplete, the CON holder is required to file a request for a six-month extension (and submit appropriate documentation) at least thirty (30) calendar days prior to the expiration of the original or any extended period.

Six-month extensions shall be based upon and supported by the CON holder's submission of documentation that shows a good faith effort to implement the CON through substantial progress. Substantial progress will be determined based upon review of the documentation submitted and whether a change in project status has occurred since the previous progress reporting period.

A fee of Two Thousand and Five Hundred Dollars ($2,500) shall be assessed for the processing and handling of six-month extension requests and is payable to the Mississippi State Department of Health by check, draft, or money order.

6.3.1 Documentation of Commencement of Construction, Good Faith Effort to Obligate Approved Expenditure, or Other Preparation Substantially Undertaken During the Valid CON Period

The following documentation may be reviewed to determine whether commencement of construction or other preparation has been substantially undertaken during a valid CON period and whether the applicant is making a good faith effort to obligate approved expenditures.

1. Commencement of Construction:

   a. Letter from the director of Health Facilities Licensure and Certification Division of the Department of Health stating that final plans have been submitted and are approved, that the plans were prepared by an architect or architectural firm licensed to do business within the State of Mississippi, and that the site is approved.

   b. A copy of a legally binding and obligating written contract executed by and between the applicant and the contractor to construct and to complete the project within a reasonable designated time schedule and to commence such construction within a reasonable designated time period and which states the specific capital expenditure amount which conforms to that amount previously approved.

   c. A copy of the contractor's Mississippi license.

   d. A copy of the building permit issued by the municipality or other applicable governing authority, or if a building permit is

not required, a letter from the municipality, county, or other governing authority stating such.

e. A letter from the municipality, county, or other governing authority that the proposed project is in compliance with zoning regulations, if any, and if no such regulations exist, a letter to that effect.

f. A statement in writing that the proposed construction project, or any preparation thereof, is not in violation of the Coastal Wetlands Protection Act, Section 49-27-1 et seq. of the Mississippi Code of 1972 Annotated, as amended, or in violation of any federal law or regulation pertaining in any manner to construction in a federally designated "wetlands" area.

g. Documentary proof that a progress payment of at least one percent of the total construction cost as set out in the contract has been paid by the applicant to the contractor (This payment exclusive of any site preparation cost).

h. A written statement signed by the applicant and the contractor stating that all site preparation work has been completed.

i. A written statement signed by the applicant and the contractor that actual bona fide construction of the proposed project has commenced and the details of such preliminary construction.

j. A copy of the Proceed to Construction Written Order previously given to the contractor.

2. Other Preparation Substantially Undertaken During the Valid CON Period [Progress may be documented by providing evidence including but not limited to, the following.]

a. Evidence To Document Progress - Construction Projects:

i. Acquisition of property (title, evidence of payment, etc.).

ii. Completion of topographic or boundary surveys

iii. Site preparation (contractor selection, contract, evidence of payment, etc.)

iv. Completion of site development plan

v. Architectural plans/drawings (architect selection, contract, evidence of payment, statement of partial completion of plans/drawings, letter evidencing submission of plans to Health Facilities Licensure and Certification, Division of Fire Safety, letter of findings, comments or remediation; resolutions

submitted; approval of commencement of construction.)

b. Evidence To Document Progress – Establishment of Service

i. Hiring or entering contracts with necessary staff/medical professionals to provide service

ii. Submission of a fire/life safety code inspection request.

iii. Submission of an application for facility inspection/ licensure.

iv. Acquisition of Equipment (Title, Lease, etc)

3. Good Faith Effort to Obligate Approved Expenditure

[Documentation may include evidence of the following items in addition to items that may be supplied under subsection 1 or 2.]

a. Document capital expenditure made to date.

b. Show evidence that permanent financing has been obtained, if approved capital expenditure has not been obligated.

c. If financing has not been obtained, show fund commitment from lending institution or agency.

d. Provide evidence of contractual obligation to expend funds.

6.3.2 If commencement of construction or other preparation is not substantially undertaken during a valid CON period, or if the Department of Health determines the CON holder is not making a good faith effort to obligate the approved expenditure, the Department shall have the right to withdraw, revoke, or rescind the certificate pursuant to Section 7.1.

6.4 EXPIRATION OF A CON

The valid period for a CON is that period stated on the CON or any subsequent extension approved by the State Health Officer. A CON holder is only authorized to proceed on the CON project including making expenditures during the valid period of a CON or any extension of the valid period. Once a CON is no longer in a valid period or any extension thereof, the CON is expired and void and the CON holder no longer has any authority under the CON and must refrain from taking any action under the expired CON**. In addition, if a CON holder fails to request Department approval for an extension prior to the CON's expiration date, the CON shall be automatically void by operation of law, and shall not require any action on the part of the Department to withdraw, revoke or rescind the certificate**. If the Department denies a request for a six-month extension, then the Department shall afford the CON holder fifteen (15) calendar days notice within which to request a hearing.

1. If a public hearing is requested, the Department will conduct the hearing within forty-five (45) calendar days of receipt of the written request,

utilizing the "Hearing During the Course of Review" procedures to the extent practicable.

2. A written request for such hearing must be received by the Department no later than fifteen (15) calendar days from the date of notice and must be accompanied by the $6,000 hearing fee.

3. The State Health Officer will render his/her written decision within thirty (30) calendar days following conclusion of any hearing on denial of the six-month extension request of the Certificate of Need.

6.5 Extension/Renewal of an Expired CON

Extenuating circumstances may prevent an applicant from proceeding with the proposed project within the valid period of the approved CON.

The Department has adopted a format for "Extension/Renewal of an Expired CON" that is to be used by proponents of a project when the increase in capital expenditure does not exceed the rate of inflation and no change in the intent or scope of the project has occurred.

This application is to be submitted and reviewed under procedures and criteria set forth in this manual for CON review in compliance with state regulations. The following criteria will be considered when reviewing projects for extension/renewal of an expired CON.:

1. Reason for expiration

2. How long has the CON been expired

3. Status of project at time of expiration and current status of project.

4. Continued need for project

5. Applicant's ability to complete the project.

6. Timeline for completion of the project.

The Department shall not consider a CON for extension/renewal that has expired more than 18 months, or one that is not shown in the current State Health Plan.

The fee assessed for prior approved projects shall be one-half of the original assessment. The minimum assessment shall be not less than $2,500.00 and the maximum fee shall not exceed $37,500.

6.6 Cost Overrun

Changes in capital expenditure not associated with substantive construction or service changes require application for a cost overrun approval. It is expected that each applicant will accurately and completely represent the cost associated with the project, so that when a CON is issued, a maximum capital expenditure is authorized.

In those cases where the expenditure maximum established by the Certificate of Need is exceeded, the applicant is required to request cost overrun approval. The following procedures shall apply to cost overrun applications.

1. The request for cost overrun shall be made in accordance with the cost overrun format.

    a. For construction projects, a revised estimate signed by an architect licensed to practice in Mississippi or a contractor authorized by law to do business in Mississippi shall accompany the request for cost overrun. The request shall include a description of the method used to determine the revised cost estimate and the justification for each line item in the budget for which a cost overrun is requested. In addition to the above, a revised capital expenditure budget outlining all costs associated with the project and a copy of any bid quotations will be submitted.

    b. In cost overrun requests for purchase of capital equipment, an official price quotation from the vendor or the manufacturer is required.

    c. Cost overrun requests for construction projects shall be compared with national construction cost data as published in the latest edition of Building Construction Cost Data, Robert S. Means Co., Inc., Kingston, Massachusetts, or other bona fide reference.

    Any cost overrun on a construction or a renovation project which locates cost in or above the upper one-fourth range for construction or renovation cost in the U.S. shall require additional documentation to explain the reasons.

    d. Cost overrun requests which result in part or in whole from the requirement of the licensure and certification authority of the State shall be given special consideration. Appropriate documentation from the licensing and/or certification authority shall be submitted with the request.

    e. The amount of the fee to be assessed on cost overruns will be calculated as follows:

    .50 of 1% of the revised capital expenditure, less the original fee, not to exceed $25,000 but not less than $2,500.00.

For any proposal in which the estimated or actual cost exceeds the amount originally approved, a review by the State Health Officer shall be required.

6.7 Amendments to Certificates of Need

A CON may be amended to reflect changes in the defined scope and/or physical location

if said amendment is necessary to be in compliance with licensing laws of the State or for certification under Title XVIII or Title XIX of the Social Security Act. Any such necessity to be in compliance shall be documented in writing from the administrative head of the Health Facilities Licensure and Certification Division.

A CON may also be amended when no substantial change exists in construction, service, or capital expenditure when extenuating circumstances or events, as determined by the State Department of Health, inhibit completion of a Certificate of Need as originally presented in final form.

Requests for amendments to CON must be submitted in writing to the Department only during the valid CON period and in the form and detail as may be required by the Department. The amount of the fee to be assessed on amendments will be calculated as follows:

.50 of 1% of the additional capital expenditure, not to exceed $25,000 but not less than $2,500.00.

NOTE: Amendments which result from an additional capital expenditure or a change in scope of project will be reviewed as a separate project and will require an additional fee.

No CON will be amended after the proponent has submitted the final report to the Department indicating completion of the project for which the Certificate of Need was issued, and the State Department of Health has acknowledged in writing the receipt of said final report.

CHAPTER 7 - PENALTIES TO ENFORCE REQUIREMENTS OF THE CERTIFICATE OF NEED ACT

7.1 Any person or entity violating the provisions of Section 41-4-171 to 41-7-209, Mississippi Code of 1972 Annotated, as amended, by not obtaining a CON, or by deviating from the provisions of a CON, or by refusing or failing to cooperate with the Department in the exercise or execution of its functions, responsibilities, and powers shall be subject to the following:

Revocation of the licensure of a health care facility or a designated section, component, or bed service thereof, or revocation of the license of any other person for which the Department is the licensing authority. If the Department lacks jurisdiction to revoke the license of such person, the State Health Officer shall recommend and show cause to the appropriate licensing agency that such license should be revoked.

Non-licensure by the Department of specific or designated bed service offered by the entity or person.

Non-licensure by the Department where infractions occur concerning the acquisition or control of major medical equipment.

Revoking, rescinding, or withdrawing a CON previously issued.

Violations of Sections 41-7-171 et seq. of Mississippi Code of 1972 Annotated, as amended, or any rules or regulations promulgated in furtherance thereof by intent, fraud, deceit, unlawful design, willful and/or deliberate misrepresentation, or by careless, negligent, or incautious disregard for such statutes or rules and regulations, either by persons acting individually or in concert with others, shall constitute a misdemeanor and shall be punishable by a fine not to exceed $1,000 for each such offense. Each day of continuing violation shall be considered a separate offense. The venue for prosecution of any such violation shall be in the county of the state wherein any such violation, or portion thereof, occurred.

The Attorney General, upon certification by the State Health Officer, shall seek injunctive relief in a court of proper jurisdiction to prevent violations of Sections 41-7- 171 et seq. of Mississippi Code of 1972 Annotated, as amended, or any rules or regulations promulgated in furtherance of these Sections in cases where other administrative penalties and legal sanctions imposed have failed or cause a discontinuance of any such violation.

Major third-party payors, public and private, shall be notified of any violation or infraction under this section and shall be required to take such appropriate punitive action as is provided by law.

CHAPTER 8 - CRITERIA USED BY STATE DEPARTMENT OF HEALTH FOR EVALUATION OF PROJECTS

8.1 General Considerations

Projects will be reviewed by the Department as deemed appropriate. Review, evaluation, and determination of whether a CON is to be issued or denied will be based upon the following general considerations and any service specific criteria which are applicable to the project under consideration.

1. **State Health Plan**: The relationship of the health services being reviewed to the applicable State Health Plan.

NOTE: CON applications will be reviewed under the State Health Plan that is in effect at the time the application is received by the Department.

No project may be approved unless it is consistent with the State Health Plan. A project may be denied if the Department determines that the project does not sufficiently meet one or more of the criteria.

2. **Long Range Plan**: The relationship of services reviewed to the long range development plan, if any, of the institution providing or proposing the services.

3. **Availability of Alternatives**: The availability of less costly or more effective alternative methods of providing the service to be offered, expanded or relocated.

4. **Economic Viability**: The immediate and long-term financial feasibility of the proposal, as well as the probable effect of the proposal on the costs and charges for providing health services by the institution or service. Projections should be reasonable and based upon generally accepted accounting procedures.

    a. The proposed charges should be comparable to those charges established by other facilities for similar services within the service area or state. The applicant should document how the proposed charges were calculated.

    b. The projected levels of utilization should be reasonably consistent with those experienced by similar facilities in the service area and/or state. In addition, projected levels of utilization should be consistent with the need level of the service area.

    c. If the capital expenditure of the proposed project is $2,000,000 or more, the applicant must submit a financial feasibility study prepared by an accountant, CPA, or the facility's financial officer. The study must include the financial analyst's opinion of the ability of the facility to undertake the obligation and the probable effect of the expenditure on present and future operating costs. In addition, the report must be signed by the preparer.

5. **Need for the Project**: One or more of the following items may be considered in determining whether a need for the project exists:

    a. The need that the population served or to be served has for the services proposed to be offered or expanded and the extent to which all residents of the area - in particular low income persons, racial and ethnic minorities, women, handicapped persons and other underserved groups, and the elderly - are likely to have access to those services.

    b. In the case of the relocation of a facility or service, the need that the population presently served has for the service, the extent to which that need will be met adequately by the proposed relocation or by alternative arrangements, and the effect of the relocation of the service on the ability of low income persons, racial and ethnic minorities, women, handicapped persons and other underserved groups, and the elderly, to obtain needed health care.

    c. The current and projected utilization of like facilities or services within the proposed service area will be considered in determining the need for additional facilities or services. Unless clearly shown otherwise, data where available from the Division of Health Planning and Resource Development shall

be considered to be the most reliable data available.

d. The probable effect of the proposed facility or service on existing facilities providing similar services to those proposed will be considered. When the service area of the proposed facility or service overlaps the service area of an existing facility or service, then the effect on the existing facility or service may be considered. The applicant or interested party must clearly present the methodologies and assumptions upon which any proposed project's impact on utilization in affected facilities or services is calculated. Also, the appropriate and efficient use of existing facilities/services may be considered.

e. The community reaction to the facility will be considered. The applicant may choose to submit endorsements from community officials and individuals expressing their reaction to the proposal. If significant opposition to the proposal is expressed in writing or at a public hearing, the opposition may be considered an adverse factor and weighed against endorsements received.

6. **Access to the Facility or Service**: The contribution of the proposed service in meeting the health related needs of members of medically underserved groups which have traditionally experienced difficulties in obtaining equal access to health services (for example, Medicaid eligible, low income persons, racial and ethnic minorities, women, and handicapped persons), particularly those needs identified in the applicable State Health Plan as deserving priority. For the purpose of determining the extent to which the proposed service will be accessible, the state agency shall consider:

a. The extent to which medically underserved populations currently use the applicant's services in comparison to the percentage of the population in the applicant's service area which is medically underserved and the extent to which medically underserved populations are expected to use the proposed services if approved;

b. The applicant's performance in meeting its obligation, if any, under any applicable federal regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to programs receiving federal financial assistance (including the existence of any civil rights access complaints against the applicant);

c. The extent to which the unmet needs of Medicare, Medicaid, and medically indigent patients are proposed to be served by the applicant; and

d. The extent to which the applicant offers a range of means by

which a person will have access to the proposed facility or services.

7. **Information Requirement**: The applicants shall affirm in their application that they will record and maintain, at a minimum, the following information regarding charity care, care to the medically indigent, and Medicaid populations and make it available to the Mississippi Department of Health within fifteen (15) business days of request:

    a. Utilization data, e.g., number of indigent, Medicaid, and charity admissions, and inpatient days of care;

    b. Age, race, sex, zip code and county of origin of patient;

    c. Cost/charges per patient day and/or cost/charges per procedure, if applicable; and

    d. Any other data pertaining directly or indirectly to the utilization of services by medically indigent, Medicaid, or charity patients which may be requested, i.e. discharge diagnosis, service provided, etc.

8. **Relationship to Existing Health Care System**: The relationship of the services proposed to be provided to the existing health care system of the area in which the services are proposed to be provided.

9. **Availability of Resources**: The availability of resources (including health personnel, management personnel, and funds for capital and operating needs) for the services proposed to be provided and the need for alternative uses of these resources as identified by the applicable State Health Plan.

    a. The applicant should have a reasonable plan for the provision of all required staff (physicians, nursing, allied health and support staff, etc.).

    b. The applicant should demonstrate that sufficient physicians are available to insure proper implementation (e.g., utilization and/or supervision) of the project.

    c. If the applicant presently owns existing facilities or services, he/she should demonstrate a satisfactory staffing history.

    d. Alternative uses of resources for the provision of other health services should be identified and considered.

10. **Relationship to Ancillary or Support Services**: The relationship, including the organizational relationship, of the health services proposed to be provided to ancillary or support services.

11. The effect of the means proposed for the delivery of health services on the clinical needs of health professional training programs in the area in which the services are to be provided.

12. **Access by Health Professional Schools**: If proposed health services are to be available in a limited number of facilities, the extent to which any health professional school in the area will have access to the services for training purposes.

13. Special needs and circumstances of those entities which provide a substantial portion of their services or resources, or both, to individuals not residing in the health services areas in which the entities are located or in adjacent health service areas. These entities may include medical and other health professional schools, multi-disciplinary clinics, and specialty centers, etc.

14. **Construction Projects**: All construction projects shall be designed and constructed with the objective of maximizing cost containment, protection of the environment, and conservation of energy. The impact of the construction costs, including financing charges on the cost of providing health care, shall be considered.

    i. Each proposal involving construction shall be accompanied by a cost estimate.

    ii. Each proposal which involves construction, modernization, or alteration of the physical plant shall be accompanied by a copy of the schematic drawings.

    iii. Space allocations should conform to applicable local, state, or minimum standards. For all projects, state or other applicable licensing standards must be met by the proposal.

    iv. For new construction projects, modernization of existing facilities should be considered as an alternative, and the rejection of this alternative by the applicant should be justified.

    v. The cost per square foot will be calculated based on the total project cost, minus cost of land and non-fixed equipment (specialized equipment such as fixed MRI, scanners, etc. are excluded from cost/square foot calculation). The following formulas will be used in calculation of the cost per square foot of projects:

    New Construction/Renovation (Prorated Project)

    Cost/square foot (New Construction) = $\frac{A+C+D+(E+F+G(A\%))*}{\text{New Const. Sq. Ft.}}$

Cost/square foot (Renovation) = $\frac{B+(E+F+G(B\%))^{**}}{\text{Renovation Sq. Ft.}}$

New Construction (No Renovation Involved)

Cost/Square Foot = $\frac{A+C+D+E+F+G}{\text{Sq. Ft.}}$

Renovation (No New Construction)

Cost/Square Foot = $\frac{B+C+E+F+G}{\text{Sq. Ft.}}$

Where:
A = New Construction
B = Renovation
C = Fixed Equipment
D = Site Preparation
E = Fees
F = Contingency
G = Capitalized Interest
* = A% refers to percentage of sq. ft. allocated to new construction
**= B% refers to percentage of sq. ft. allocated to renovation

15. **Competing Applications**: The factors which influence the outcome of competition on the supply of health services being reviewed. Determination will be made that the entity approved is the most appropriate applicant for providing the proposed health care facility or service. Such determination may be established from the material submitted as to the ability of the person, directly or indirectly, to render adequate service to the public. Additional consideration may be given to how well the proposed provider can meet the criteria of need, access, relationship to existing health care system, availability of resources, and financial feasibility. In addition, the Department may use a variety of statistical methodologies, including but not limited to, "market share analysis," patient origin data, and state agency reports. In the matter of competing applications for nursing facility beds, the Department will conduct a comparative analysis and make a determination based upon a ranking of all competing applications according to the following factors: size of facility; capital expenditure; cost per square foot; cost per bed; staffing; Medicare utilization; total cost to Medicaid; per diem cost to Medicaid; continuum of care services, and community support*. Each factor shall be assigned an equal weight. The application obtaining the lowest composite score in the ranking will be considered the most appropriate application.

Note: Community support letters submitted by and on behalf of an applicant for a CON for a nursing facility are valid only if signed by individuals who are eighteen (18) years of age or older and who reside in the county in which the proposed

nursing facility will be located. In addition, each letter shall contain the name, address, occupation,

telephone number of the signee, and certification that he/she is 18 years of age or older.

Any nursing facility applicant, who signs a written agreement to maintain continuous ownership and operation of the proposed nursing facility for a period of not less than three (3) years after initial licensure and who includes said agreement as part of the Certificate of Need application, shall have one point deducted from the total composite score of that application. However, in the event of default on the agreement (selling or leasing said facility in less than three (3) years from initial licensure) by an applicant, the applicant will be penalized by being barred from filing a CON application for a nursing facility for a period of three (3) years from the date of default.

16. **Quality of Care**: In the case of existing services or facilities, the quality of care provided by those facilities in the past.

8.2 Supplemental Service-Specific Criteria

Service-specific criteria have been developed for a number of health services and are contained in the State Health Plan. Applications that propose to develop or expand such services will be measured against the applicable general criteria listed in this section and also against the Service Specific Criteria contained in the State Health Plan and the adopted rules and regulations of the Department. The Supplemental Standards and Criteria shall be used by the Department to determine the need for new acute and long- term care hospital beds, psychiatric and chemical dependency facilities, comprehensive inpatient rehabilitation facilities, facilities for the mentally retarded, ESRD facilities, cardiac catheterization laboratories, open heart surgical services, therapeutic radiation services, diagnostic imaging services, home health services, magnetic resonance imaging services, extracorporeal shockwave lithotripsy services, positron emission tomography services, etc.

8.3 Required Findings on Access

Findings on access (see Criterion 6 of this chapter) must be included in the written findings of the State Department of Health for each project approved, except where the project is one which was undertaken to eliminate or prevent eminent safety hazards or to comply with certain licensure or accreditation standards regarding life safety codes or regulations, where the project proposes a capital expenditure not directly related to the provision of health services or to beds or major medical equipment, or where the project is proposed by or on behalf of a health care facility which is controlled directly or indirectly by an HMO.

In making its written findings on access, the Department must take into account the current accessibility of the facility as a whole.

The Department may impose a condition that requires the applicant to take affirmative steps to meet access criteria on those projects that were approved but do not meet access criteria.

The Department must state in its written findings if a project is disapproved for failure to meet the need and access criteria.

In any case where the Department finds that a project does not satisfy the criteria for access to traditionally underserved groups, a report of such findings shall be made in writing to the applicant.

CHAPTER 9 - JUDICIAL RECOURSE

9.1 Appeal of the Decision of the State Health Officer by an Aggrieved Party

There shall be a "stay of proceedings" of any final order issued by the State Department of Health pertaining to the issuance of a certificate of need for the establishment, construction, expansion or replacement of a health care facility for a period of thirty (30) calendar days from the date of the order, if an existing provider located in the same service area where the health care facility is or will be located has requested a hearing during the course of review in opposition to the issuance of the certificate of need. The stay of proceedings shall expire at the termination of thirty (30) calendar days; however, no construction, renovation or other capital expenditure that is the subject of the order shall be undertaken, no license to operate any facility that is the subject of the order shall be issued by the licensing agency, and no certification to participate in the Title XVII or Title XIX programs of the Social Security Act shall be granted, until all statutory appeals have been exhausted or the time for those appeals has expired. Notwithstanding the foregoing, the filing of an appeal from a final order of the State Department of Health for the issuance of a certificate of need shall not prevent the purchase of medical equipment or development or offering of institutional health services granted in a certificate of need issued by the State Department of Health.

In addition to other remedies now available at law or in equity, any party aggrieved by any such final order of the State Department of Health shall have the right of direct appeal to the Chancery Court of the First Judicial District of Hinds County, Mississippi, which appeal must be filed within twenty (20) calendar days after the date of the final order. Provided, however, that any appeal of an order disapproving an application for such a certificate of need may be made to the chancery court of the county where the proposed construction, expansion or alteration was to be located or the new service or purpose of the capital expenditure was to be located. Such appeal must be filed in accordance with the twenty (20) calendar days for filing as heretofore provided. Any appeal shall state briefly the nature of the proceedings before the State Department of Health and shall specify the order complained of. Any person whose rights may be materially affected by the action of the State Department of Health may appear and become a party or the court may, upon motion, order that any such person, organization or entity be joined as a necessary party.

Upon the filing of such an appeal, the clerk of the chancery court shall serve notice thereof upon the State Department of Health, whereupon the State Department of Health shall, within thirty (30) calendar days of the date of the filing of the appeal or within such time as the court may by order for cause allow from the service of such notice, certify to the chancery court the record in the case, which records shall include a transcript of all testimony, together with all exhibits or copies thereof, all pleadings, proceedings, orders, findings and opinions entered in the case; provided, however, that the parties and the State Department of Health may stipulate that a specified portion only of the record shall be certified to the court as the record on appeal. The chancery court shall give preference to any such appeal from a final order by the State Department of Health in a certificate of need proceeding, and shall render a final order regarding such appeal no later than one hundred twenty (120) calendar days from the date of the final order by the State Department of Health. If the chancery court has not rendered a final order within this 120-day period, then the final order of the State Department of Health shall be deemed to have been affirmed by the chancery court, and any party to the appeal shall have the right to appeal from the chancery court to the Supreme Court on the record certified by the State Department of Health as otherwise provided in this section. In the event the chancery court has not rendered a final order within the 120-day period and an appeal is made to the Supreme Court as provided herein, the Supreme Court shall remand the case to the chancery court to make an award of costs, fees, reasonable expenses and attorney's fees incurred in favor of the appellee payable by appellant(s) should the Supreme Court affirm the order of the State Department of Health.

Any appeal of a final order by the State Department of Health in a certificate of need proceeding shall require the giving of a bond by the appellant(s) sufficient to secure the appellee against the loss of costs, fees, expenses and attorney's fees incurred in defense of the appeal, approved by the chancery court within five (5) calendar days of the date of filing the appeal.

No new or additional evidence shall be introduced in the chancery court, but the case shall be determined upon the record certified to the court.

The court may sustain or dismiss the appeal in term time or vacation and may sustain or dismiss the appeal, modify or vacate the order complained of, in whole or in part, and may make an award of costs, fees, expenses and attorney's fees, as the case may be; but in case the order is wholly or partly vacated, the court may also, in its discretion, remand the matter to the State Department of Health for any further proceedings, not inconsistent with the court's order, as, in the opinion of the court, justice may require. The court, as part of the final order, shall make an award of costs, fees, reasonable expenses and attorney's fees incurred in favor of appellee payable by the appellant(s) if the court affirms the order of the State Department of Health.

The order shall not be vacated or set aside, either in whole or in part, except for errors of law, unless the court finds that the order of the State Department of Health is not supported by substantial evidence, is contrary to the manifest weight of the evidence, is in excess of the statutory authority or jurisdiction of the State Department of Health, or violates any vested constitutional rights of any party involved in the appeal. Provided, however, an order of the chancery court reversing the denial of a certificate of need by the State Department of Health shall not entitle the applicant to effectuate the certificate of need until either: (1) such order of the chancery court has become final and has not been appealed to the Supreme Court; or (ii) the Supreme Court has entered a final order affirming the chancery court.

Appeals in accordance with law may be had to the Supreme Court of the State of Mississippi from any final judgment of the chancery court.

Within thirty (30) calendar days from the date of a final order by the Supreme Court or a final order of the chancery court not appealed to the Supreme Court that modifies or wholly or partly vacates the final order of the State Department of Health granting a certificate of need, the State Department of Health shall issue another order in conformity with the final order of the Supreme Court, or the final order of the chancery court not appealed by the Supreme Court.

9.2 Appeal of the Proponent When the Department Fails to Render a Decision in Required Time

Unless a hearing is held, if review by the State Department of Health concerning the issuance of a CON is not complete with a final decision issued by the State Health Officer within the time specified by rule or regulations, which shall not exceed ninety (90) calendar days from the filing of the application for a certificate of need, the proponent of the proposal may, within thirty (30) calendar days after the expiration of the specified time for review, commence such legal action as is necessary in the Chancery Court of the First Judicial District of Hinds County or in the Chancery Court of the county in which the service or facility is proposed to be provided to compel the Department to issue written findings and written order approving or disapproving the proposal in question.

Title 15: Mississippi State Department of Health

Part 9: Office of Health Policy and Planning

Subpart 95: Appalachian Regional Commission "ARC" J-1 Visa Waiver Guidelines

Chapter 1. MISSISSIPPI STATE DEPARTMENT OF HEALTH APPALACHIAN REGIONAL COMMISSION "ARC" J-1 VISA WAIVER GUIDELINES

Subchapter 1. INTRODUCTION

Rule 1.1.1. The Mississippi State Department of Health (MSDH) is committed to assuring that all Mississippi residents have access to quality, affordable health care. The Mississippi Office of Rural Health and Primary Care reviews applications and makes recommendations to the Appalachian Regional Commission, hereafter referred to as the "ARC", in regards to the primary care J-1 visa waiver placements within that region of the state. The applications will be reviewed for completeness, and inclusion of all appropriate documentation, as required by the federal agency.

1. The primary purpose of the Mississippi J-1 Visa Waiver Programs is to improve access to primary health care in physician shortage areas in Mississippi and secondarily, to needed specialty care, by sponsoring physicians holding J-1 Visas.

2. The State of Mississippi recognizes that the J-1 Visa Waiver Program affords J-1 Visa holders the privilege of waiving their two-year foreign residency requirement in exchange for providing primary or specialty medical care in designated health professional shortage areas.

3. The provision of assistance to the ARC in the administration of this program is designed to be consistent with the federal requirements of the program resulting in added benefits to the State of Mississippi.

4. The purpose of the following Guidelines is to articulate the conditions under which the State of Mississippi will provide a recommendation to the ARC.

5. Health care facilities/sites interested in employing J-1 Visa Waiver physicians must submit an ARC 30 J-1 Visa Waiver Application to the Mississippi Office of Rural Health and Primary Care to determine if the proposed J-1 physician placement will qualify for the Program.

6. The recommendations provided to the ARC will in no way interfere with placements through the "Conrad State 30 Program". The Mississippi J-1 Visa

Waiver Program through the "Conrad State 30 Program" is a separate and distinct program from any other program and is an additional program to any now operating within the State of Mississippi.

7. The Mississippi State Department of Health's Guidelines are completely discretionary, voluntary, and may be modified or terminated at any time. The submission of a complete waiver package to the MSDH does not ensure an automatic waiver recommendation. In all instances, MSDH reserves the right to recommend or deny any request for a waiver.

8. HPSA designations must be current on the date the U.S. Department of State reviews the application and on the date the INS approves the J-1 visa waiver. Therefore, any application that is being submitted to the Mississippi State Department of Health at the end of the three-year HPSA designation cycle may be summarily denied if the renewal of the HPSA designation is not obtained.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.1.2. [RESERVED]

Rule 1.1.3. [RESERVED]

Rule 1.1.4. [RESERVED]

Rule 1.1.5. An Employer/Medical Facility eligible to recruit and hire J-1 Visa physicians through the program must be a facility that meets one of the following criteria:

a. A public health facility, an ambulatory medical facility, a community health center, a community mental health center; or

b. A hospital or state mental hospital.

SOURCE: Miss. Code Ann. §41-3-17

Subchapter 2. GENERAL GUIDELINES:

Rule 1.2.1. The State of Mississippi is prepared to make recommendations to the ARC on behalf of Mississippi health care facilities for physicians holding J-1 Visas for the purpose of waiving the two-year foreign residency requirement. All conditions of the following ARC and Mississippi J-1 Visa Waiver policies/guidelines must be met. Employers are encouraged to impose additional provisions in order to assure that the delivery of care is consistent with their facility's policies.

1. Physicians who have completed a U.S. residency training program in family practice, general practice, general internal medicine, general pediatrics, and obstetrics/gynecology are considered to be primary care physicians. Psychiatrists are also considered for the program. Waiver recommendations for physicians who will practice specialty medicine may be made with an appropriate showing of need.

2. The medical facility or practice must be located in a county or portion of county currently designated by the United States Department of Health and Human Services as a HPSA for primary medical care or mental health, in the case of the recruitment of psychiatrists.

3. All requests must at a minimum, include the following:

   a. The ARC Federal Co-Chair Cover Letter.

   b. The ARC J-1 Visa Waiver Policy Affidavit and Agreement.

   c. Attestation of the ARC J-1 Visa Liquidated Damages Clause.

   d. Information describing the public benefit of approval of the placement.

   e. Attestation that site provides health care services to Medicare and Medicaid- eligible patients, indigent patients, and uninsured patients. And, the percentage of Medicaid, Medicare, indigent, and uninsured patients served by site.

   f. Proof that practice site is located in a HPSA or the documentation required to prove the practice is serving patients from a nearby HPSA.

   g. Evidence that other avenues, regionally and nationally, to secure a physician not bound by the 2-year home residence requirement have been undertaken over a period of at least three (3) months. The recruitment must have occurred prior to submission of the ARC 30 J-1 Visa Waiver Application.

   h. Information about the home government "No Objection" requirement.

   i. A copy of notarized, dated, executed tentative employment contract indicating three (3) year full-time (40 hours per week) employment with the sponsoring medical facility.

   j. Information about the applying physician.

   k. Attestation that the physician will start employment within 90 days of receiving the waiver.

   l. Attestation to submit the MSDH Annual J-1 Visa Waiver Physician Employment Verification Form.

   m. The required documentation for specialist applicants.

   n. An indication of whether the applying physician is a party to any existing

or possible future (one that may occur within the obligation period) petition that would result in the applying physician not having to complete the service obligation.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.2.2. [RESERVED]

Rule 1.2.3. Waiver requests must be submitted by the employer or the employer's representative. All employment contracts must be between the sponsoring employer and the J-1 Visa physician.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.2.4. The facility or practice where the J-1 physician will work must have been operational at least six months at the time the waiver request is submitted. Evidence should include the business license and occupancy permit, facility address, fax and telephone numbers, staffing list. Exceptions may be considered.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.2.5. The facility or practice must accept all patients regardless of ability to pay. The sponsoring entity must agree to provide services to individuals without discriminating against them because (a) they are unable to pay for those services and/or (b) payment for those health services will be made under Medicare and Medicaid. The sponsor may charge no more than the usual and customary rate prevailing in the HPSA in which services are provided.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.2.6. The facility must have a schedule of discounts or an adopted sliding fee scale. Charges must be discounted for persons at or below 200 percent of poverty level. If the person is unable to pay the charge, such person shall be charged at a reduced rate in accordance with an adopted and utilized policy or not charged at all.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.2.7. The J-1 Visa physician must accept assignment under Section 1842 (b)(3)(ii) of the Social Security Act as full payment for all services for which payment may be made under Part B of Title XVIII of such act (Medicare).

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.2.8. The J-1 Visa physician must enter into an appropriate agreement with the

Mississippi state agency which administers the state plan for medical assistance under Title XIX of the Social Security Act (Medicaid) to provide services to individuals entitled to medical assistance under the plan.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.2.9. The employer must make known to the HPSA community that the J-1 physician will comply with the terms and conditions stated in the Guidelines by posting a notice in a conspicuous place in the waiting area of the practice stating that all patients will be seen regardless of their ability to pay.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.2.10. [RESERVED]

Rule 1.2.11. The physician must not have been "out of status" (as defined by the Immigration and Naturalization Service of the United States Department of Justice) for more than 180 days since receiving a visa under 8 USC 1182 (j) of the Immigration and Nationality Act, as amended. The physician shall provide the FCC all copies of his or her Certificates of Eligibility for Exchange Visitor (J-1) Status forms and every other document needed to verify status, including a copy of the federal J-1 Visa Waiver Recommendation Application. The name of the foreign trained provider must be provided during the ARC 30 J-1 Visa Waiver Application process in order to remain compliant with this requirement.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.2.12. A statement in writing is required indicating that the home government has no objection to the waiver if the physician's medical education or training has been funded by the government of the graduate's home country. He or she should obtain this statement from the physician's embassy in Washington or home country. The "No Objection" statements for these physicians should contain the following or similar language: *"Pursuant to Public Law 103-416, the government of (Country) has no objection if (name and address of the foreign medical graduate) does not return to (Country) to satisfy the two-year foreign residence requirement of 212(e) of the Immigration and Nationality Act (INA)."*

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.2.13. The J-1 physician and his/her employer must, on commencement of practice and annually thereafter through the contract period, verify the physician's practice site address and field of practice. The reporting can be submitted on the "J-1 Visa Physician Verification of Employment Form" contained in this application packet. The first report must be submitted within 30 days**.** For

population based HPSAs, documentation that the population the foreign physician was placed there to serve was indeed served must be submitted. The final report must indicate whether the J-1 physician intends to remain in the shortage area to practice. Failure to submit accurate reports in a timely manner that complies with the Mississippi J-1 Visa Waiver Guidelines will jeopardize future recommendations for J-1 Visa physician placements. These verification forms will be shared with the ARC.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.2.14. The J-1 Visa Waiver physician must remain in employment for a total of not less than three (3) years, at the site(s) listed in the ARC J-1 Visa Waiver Application and for which the waiver is approved, unless the physician petitions the United States Citizen and Immigration Services for early termination of the 3-year period because the practice site closes or due to extenuating circumstances.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.2.15. [RESERVED]

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.2.16. [RESERVED]

Subchapter 3. EMPLOYMENT CONTRACT:

Rule 1.3.1. The J-1 physician is responsible for locating and negotiating a contract for a minimum of three (3) years and preferably four (4) years (unless the service requirement is amended) to provide care a minimum of 40 hours per week, as a primary care physician or psychiatrist in a federally designated HPSA in Mississippi. The 40 hours must be performed during normal office hours, or hours which best suit the needs of the community and may not be performed in less than four (4) days a week. A weekly schedule must be included in all waiver requests. It is recommended that each party have its own legal representation in preparation of the contract.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.3.2. The J-1 physician must be board-eligible in his/her field of practice and eligible for Mississippi licensure.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.3.3. By regulation (Immigration and Nationality Act, as amended, section 214(k)(1) [8U.S.C. §1184 (k)(1)]), the J-1 physician must commence practice within 90 days of receiving a waiver.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.3.4. The J-1 Visa physician must agree in writing that he or she will begin employment within 90 days of receiving a waiver; and a statement from the J-1 Visa physician regarding planned commitment to the community should be provided.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.3.5. The ARC will be notified if a J-1 physician is found not to have reported or not be practicing medicine a minimum of 40 hours per week in the location for which the recommendation was made.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.3.6. MSDH must be notified when the J-1 physician does not report for duty.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.3.7. The employer and/or J-1 physician must notify MSDH of breach or termination of contract.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.3.8. For the statutorily required period there can be no changes to the contract that would result in the J-1 physician leaving the agreed-upon site and no longer treating the patients he/she has agreed to treat in the manner agreed upon, unless the physician has petitioned the United States Citizen and Immigration Services.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.3.9. The contract should not state commencement or expiration dates. It is a tentative contract based on the application being approved through ARC, U.S. Department of State and INS.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.3.10. A non-competition clause or any provision that purports to limit the J-1 physician's ability to remain in the area upon completion of the contract term is prohibited by regulation.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.3.11. The contract must include a liquidation damages clause as required by the ARC. Specific wording to be included in the contract is included in this packet. However, any clauses that would require the J-1 physician to pay a sum to the employer for experience gained on the job or for the J-1 physician remaining in

the area after the contract has ended are not allowed.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.3.12. Include in all employment contracts the following information:

1. guaranteed 3-year base salary
2. benefits
3. Insurance
4. field of practice, practice site name and address for 40 hours for at least 4 days per week, not including travel and on-call time; days and hours on site, if multiple sites.
5. leave (annual, sick, continuing medical education, holidays)
6. commencement date begins within 90 days of receipt of J-1 visa waiver
7. statement that amendments shall adhere to ARC and Federal J-1 visa waiver requirements

SOURCE: Miss. Code Ann. §41-3-17

Subchapter 4. RECRUITMENT:

Rule 1.4.1. The medical facility must provide evidence that other avenues, regionally and nationally, to secure a physician not bound by the 2-year home residence requirement have been undertaken over a period of at least three (3) months. The recruitment must have occurred prior to submission of the ARC 30 J-1 Visa Waiver Application.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.4.2. Recruitment efforts must have regional and national reach. Recruitment information must state the position available and the practice site location.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.4.3. Ads run at the time of or after submission of the ARC 30 J-1 Visa Waiver Application are not usable.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.4.4. Documentation of recruitment efforts may include:

1. Copies of the regional and national print advertising ads (copies of ads must show publication date).

2. Online ads (must show the date the ad was online).

3. Copies of certified letters to medical schools.

4. Other forms of recruitment documentation will be reviewed to determine if information for the specific position required in the Mississippi ARC State 30 J-1 Visa Waiver Application is clearly identified and to determine if sufficient date information is available to verify three (3) months of recruitment effort.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.4.5. The sponsoring health care facility is required to publish a legal notice in their local newspaper of general circulation in accordance with the following format. The Proof of Publication of this notice must be submitted with the ARC 30 J-1 Visa Waiver Application.

1. (Name of J-1 sponsoring facility and complete mailing address) is requesting that the Mississippi State Department of Health support a J-1 Visa waiver of the two- year foreign residency requirement of (physician discipline) in exchange for (Primary Care or Specialty Care) health services to (name of underserved area), an underserved area of the state, if approved by the U.S. Department of State.

2. Letters of support or opposition can be sent to Director, Office of Rural Health and Primary Care, Mississippi State Department of Health, P.O. Box 1700, Jackson, MS 39215-1700. Any interested party has 21 calendar days from the date of this publication to submit letters.

3. Copies of letters may be obtained from the Office of Rural Health and Primary Care at the Mississippi State Department of Health.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.4.6. Priority hire must be given to physicians other than J-1 physicians (presumably H-1Bs) who apply for the waiver job and are qualified. The employer must show that hiring a J-1 physician is a last resort.

SOURCE: Miss. Code Ann. §41-3-17

Subchapter 5. PROHIBITIONS:

Rule 1.5.1. MSDH will not consider recommendations when the provisions of Subchapter 2 have not been met and under the following circumstances:

1. Preliminary determinations over the telephone prior to final review of the ARC 30 J-1 Visa Waiver Application being completed.

2. The medical facility is not located in an Appalachian Regional

Commission County.

3. Medical facilities located in those counties which are a part of the Appalachian Regional Commission who are not recruiting primary care physicians.

4. More than two (2) ARC 30 J-1 Visa Waiver Applications per employer each federal fiscal year. Exceptional circumstances will be reviewed on a case-by-case basis (depending on the number of remaining waivers and unmet needs in community and state).

5. Requests for a J-1 physician whose last Certificate of Eligibility for Exchange Visitor status has expired more than 210 days prior to the time the ARC 30 J-1 Visa Waiver Application request is submitted.

6. Requests from an employer who is a former J-1 physician currently fulfilling his/her required 3-year obligation.

7. A waiver for a relative or acquaintance of the employer.

8. A J-1 physician showing signs of active tuberculosis without a MSDH approved plan for treatment and an approved provision for payment of testing, treatment, and follow-up.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.5.2. Requests from an employer who is a former J-1 physician currently fulfilling his/her required 3-year obligation.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.5.3. A waiver for a relative or acquaintance of the employer.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.5.4. [RESERVED]

SOURCE: Miss. Code Ann. §41-3-17

Subchapter 6. TRANSFERS:

Rule 1.6.1. The J-1 Visa waiver physician must remain in employment for a total of not less than three (3) years, at the site(s) listed in the Mississippi ARC J-1 Visa Waiver Application and for which the waiver is approved, unless the physician petitions the United States Citizen and Immigration Services for early termination of the 3- year period because the practice site closes or due to extenuating circumstances.

1. The J-1 Visa Waiver physician must notify the MSDH in writing as soon as possible of their intent to petition the United States Citizen and Immigration

Services for early termination of the 3-year period because the practice site

closes or due to extenuating circumstances.

2. To work at another facility the J-1 Visa Waiver physician must amend or file a new H-1B petition with the United States Citizen and Immigration Services.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.6.2. The J-1 physician retains sole responsibility for notifying their current employer of the intent to petition the United States Citizen and Immigration Services for early termination of the 3-year period, and payment of any financial penalty caused by a breach of contract.

SOURCE: Miss. Code Ann. §41-3-17

Subchapter 7. FOREIGN PHYSICIANS RELEASED DUE TO TERMINATION, MUTUAL RELEASE, OR DEATH:

Rule 1.7.1. The Mississippi Office and Primary care must be informed in writing by the sponsoring employer of the following circumstances:

1. the sponsoring employer determines that there is reasonable cause to terminate the employment contract of a foreign provider;

2. the employer and foreign provider mutually agree to the release from employment;

3. there are no funds to reimburse the foreign provider for their services; or

4. there is a loss due to the death of the foreign provider.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.7.2. The Mississippi Office of Rural Health and Primary Care will assist, in a limited way, the sponsoring employer and foreign physician in resolving termination disputes. However, the Mississippi Office of Rural Health and Primary Care will assume no position in the dispute.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.7.3. The Mississippi Office of Rural Health and Primary Care will assist, in a limited way, the foreign provider in securing another position in the state.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.7.4. J-1 Visa Waiver physicians who are released from the sponsoring medical

facility prior to the completion of the federally required three (3) year full-time

service obligation must amend or file a new H-1B petition with the United States Citizen and Immigration Services to complete the service obligation at another facility.

The J-1 Visa Waiver physician must notify the MSDH that he/she is petitioning.

SOURCE: Miss. Code Ann. §41-3-17

Subchapter 8. NATIONAL INTEREST WAIVER (NIW) LETTER REQUESTS:

Rule 1.8.1. Please refer to the Mississippi State Department of Health National Interest Waiver Guidelines for the requirements for consideration of a support letter for a NIW application.

Rule 1.8.2. [RESERVED]

Rule 1.8.3. [RESERVED]

Rule 1.8.4. [RESERVED]

Rule 1.8.5. [RESERVED]

Rule 1.8.6. [RESERVED]

Rule 1.8.7. [RESERVED]

Rule 1.8.8. [RESERVED]

Rule 1.8.9. [RESERVED]

Rule 1.8.10. [RESERVED]

Rule 1.8.11. [RESERVED]

Rule 1.8.12. [RESERVED]

Rule 1.8.13. [RESERVED]

Rule 1.8.14. [RESERVED]

Rule 1.8.15. [RESERVED]

Rule 1.8.16. [RESERVED]

Rule 1.8.17. [RESERVED]

SOURCE: Miss. Code Ann. §41-3-17

Chapter 2. CERTIFICATION OF COMPLIANCE WITH THE MISSISSIPPI J-1 VISA WAIVER PROGRAM

Rule 2.1.1. [RESERVED]

Rule 2.1.2. [RESERVED]

Rule 2.1.3. [RESERVED]

Title 15: Mississippi State Department of Health

Part 9: Office of Health Policy and Planning

Subpart 96: Mississippi Conrad State 30 J-1 Visa Waiver Guidelines

Chapter 1. MISSISSIPPI CONRAD STATE 30 J-1 VISA WAIVER PROGRAM GUIDELINES

Subchapter 1. INTRODUCTION

Rule 1.1.1. The Mississippi State Department of Health (MSDH) is committed to assuring that all Mississippi residents have access to quality, affordable health care. The Office of the State Health Officer maintains the responsibility within the state of recommending and processing, through its Mississippi Office of Rural Health and Primary Care, J-1 Visa waiver requests for the United States Information Agency's (USIA) ”Conrad State 30 Program".

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.1.2. The primary purpose of the Mississippi J-1 Visa Waiver Program through the "Conrad State 30 Program” is to improve access to primary health care in physician shortage areas in Mississippi and, secondarily to needed specialty care, by sponsoring physicians holding J-1 Visas.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.1.3. Healthcare facilities/sites interested in employing J-1 Visa Waiver physicians must submit a complete Mississippi Conrad State 30 J-1 Visa Waiver Application to the Mississippi Office of Rural Health and Primary Care to determine if the proposed J-1 physician placement will qualify for the Program.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.1.4. A non-refundable processing fee of $2,000.00 is required to process a complete Mississippi Conrad State 30 J-1 Visa Waiver Application. A check or money order from the sponsoring facility should be made payable to the Mississippi State Department of Health and submitted with the complete Mississippi Conrad State 30 J-1 Visa Waiver Application. No complete Mississippi Conrad State 30 J-1 Visa Waiver Application will be processed without payment of the processing fee. The US Department of State requires that the J-1 Visa Waiver Data Sheet DS- 3035 be submitted to the appropriate address contained in the Department's policies, along with their required user processing fee and two self-addressed, stamped, legal-size envelopes. For additional information, contact the US Department of State or visit their website.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.1.5. The USIA file number must be placed on each page of the Mississippi Conrad State 30 J-1 Visa Waiver Application.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.1.6. The State of Mississippi recognizes that the J-1 Visa Waiver Program through the "Conrad State 30 Program" affords J-1 Visa holders the privilege of waiving their two-year foreign residency requirement in exchange for providing primary or specialty medical care in designated health professional shortage areas.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.1.7. The operation of the Mississippi J-1 Visa Waiver Program through the "Conrad State 30 Program" is designed to be consistent with other health care programs and policies of the State of Mississippi.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.1.8. The purpose of the following Guidelines is to articulate the conditions under which the State of Mississippi will request a waiver for physicians holding J-1 Visas through the "Conrad State 30 Program". Information on currently designated health professional shortage areas (HPSAs) for primary medical care or mental health recommendations will be provided upon request. Medical facilities located in those counties which are a part of the Appalachian Regional Commission are not eligible to recruit primary care J-1 Physicians through the program, with the exception of psychiatrists and specialists.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.1.9. The review cycle begins upon MSDH receipt of the Mississippi Conrad State 30 J-1 Visa Waiver Application and must be concluded within 180 days.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.1.10. The operation of the Mississippi J-1 Visa Waiver Program through the "Conrad State 30 Program" will in no way interfere with any other J-1 Visa Waiver Program including, but not limited to, placements through the MSDH Mississippi Office of Rural Health and Primary Care for the Appalachian Regional Commission. The Mississippi J-1 Visa Waiver Program through the "Conrad State 30 Program" is a separate and distinct program from any other program and is an additional program to any now operating within the State of Mississippi.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.1.11. The Mississippi State Department of Health's Guidelines are completely discretionary, voluntary, and may be modified or terminated at any time. The submission of a complete waiver package to the MSDH does not ensure an

automatic waiver recommendation. In all instances, MSDH reserves the right to recommend or deny any request for a waiver.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.1.12. J-1 Visa Waiver physicians must practice at sites physically located in a currently designated federal Health Professional Shortage Area (HPSA) or at a site currently providing services to residents of a currently designated HPSA.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.1.13. An Employer/Medical Facility eligible to recruit and hire J-1 Visa physicians through the Program must be a facility that meets one of the following criteria:

1. a public health facility, an ambulatory medical facility, a community health center, a community mental health center; or

2. a hospital or state mental hospital.

SOURCE: Miss. Code Ann. §41-3-17

Subchapter 2. GENERAL GUIDELINES:

Rule 1.2.1. The State of Mississippi is prepared to request through the Program waivers for physicians holding J-1 Visas for the purpose of waiving the two-year foreign residence requirement. All conditions of the following Mississippi Conrad State 30 J-1 Visa Waiver Guidelines must be met. Employers are encouraged to impose additional provisions in order to assure that the delivery of care is consistent with their facility's policies.

1. Physicians who have completed a U.S. residency training program in family practice, general practice, general internal medicine, general pediatrics, and obstetrics/gynecology are considered primary care physicians and are eligible to participate in Mississippi's "Conrad State 30" J-1 Visa Waiver Program. Psychiatrists may also be considered for the program. Physicians with other specialties are not considered to be primary care physicians for the purpose of the Program.

2. Physicians trained in other specialties may be considered for placement in designated areas of shortage in accordance with the addendum section for specialists of the Mississippi Conrad State 30 J-1 Visa Waiver Application.

3. It is recognized that emergency rooms are utilized for primary care services by some populations. Requests for emergency room physicians will be considered, however, as a specialty and will require documentation that primary care services are inadequate within the service area.

4. The medical facility or practice must be located in a county or portion of county currently designated by the United States Department of Health and Human Services as a HPSA for primary medical care or mental health, in the case of the recruitment of psychiatrists.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.2.2. All requests must at a minimum, include the following:

1. Information describing the public benefit of approval of the placement.

2. Attestation that site provides health care services to Medicare and Medicaid-eligible patients, indigent patients, and uninsured patients. And, the percentage of Medicaid, Medicare, indigent, and uninsured patients served by site.

3. Proof that practice site is located in a HPSA or the documentation required to prove the practice is serving patients from a nearby HPSA.

4. Evidence that other avenues, regionally and nationally, to secure a physician not bound by the 2-year home residence requirement have been undertaken over a period of at least three (3) months. The recruitment effort must have occurred prior to submission of the Mississippi Conrad State 30 J-1 Visa Waiver Application.

5. Information about the home government "No Objection" requirement.

6. A copy of notarized, dated, executed tentative employment contract indicating three (3) year full-time (40 hours per week) employment with the sponsoring medical facility.

7. Information about the applying physician.

8. Attestation that the physician will start employment within 90 days of receiving the waiver.

9. Attestation to submit the MSDH Annual J-1 Visa Waiver Physician Employment Verification Form.

10. The required documentation for specialist applicants.

11. An indication of whether the applying physician is a party to any existing or possible future (one that may occur within the obligation period) petition that would result in the applying physician not having to complete the service obligation.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.2.3. [RESERVED]

Rule 1.2.4. Waiver requests must be submitted by the employer or the employer's representative. All employment contracts must be between the sponsoring employer and the J-1 Visa physician.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.2.5. The facility or practice where the J-1 physician will work must have been operational at least six months at the time the waiver request is submitted. Evidence should include the business license and occupancy permit, facility address, fax, and telephone numbers, staffing list. Exceptions may be considered.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.2.6. The facility or practice must accept all patients regardless of ability to pay. The sponsoring entity must agree to provide services to individuals without discriminating against them because (a) they are unable to pay for those services and/or (b) payment for those health services will be made under Medicare and Medicaid. The sponsor may charge no more than the usual and customary rate prevailing in the HPSA in which services are provided.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.2.7. The facility must have a schedule of discounts or an adopted sliding fee scale. Charges must be discounted for persons at or below 200 percent of poverty level. If the person is unable to pay the charge, such person shall be charged at a reduced rate in accordance with an adopted and utilized policy or not charged at all.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.2.8. The J-1 Visa physician must accept assignment under Section 1842 (b)(3)(ii) of the Social Security Act as full payment for all services for which payment may be made under Part B of Title XVIII of such act (Medicare).

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.2.9. The J-1 Visa physician must enter into an appropriate agreement with the Mississippi state agency, which administers the state plan for medical assistance under Title XIX of the Social Security Act (Medicaid) to provide services to individuals entitled to medical assistance under the plan.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.2.10. The employer must make known to the HPSA community that the J-1 physician will comply with the terms and conditions stated in the Guidelines by posting a notice in a conspicuous place in the waiting area of the practice stating that all patients will be seen regardless of their ability to pay.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.2.11. [RESERVED]

Rule 1.2.12. The physician must not have been "out of status" (as defined by the Immigration and Naturalization Service of the United States Department of Justice) for more than 210 days since receiving a visa under 8 USC 1182 (j) of the Immigration and Nationality Act, as amended. The physician shall provide the FCC all copies of his or her Certificates of Eligibility for Exchange Visitor (J-1) Status forms and every other document needed to verify status, including a copy of the federal J Waiver Visa Recommendation Application. The name of the foreign trained provider must be provided in the Mississippi Conrad State 30 J-1 Visa Waiver Application in order to remain compliant with this requirement.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.2.13. A statement in writing is required indicating that the home government has no objection to the waiver if the physician's medical education or training has been funded by the government of the graduate's home country. He or she should obtain this statement from the physician's embassy in Washington or home country. The "No Objection" statements for these physicians should contain the following or similar language:

Pursuant to Public Law 103-416, the Government of (Country) has no objection if (name and address of the foreign medical graduate) does not return to (Country) to satisfy the two-year foreign residence requirement of 212(e) of the Immigration and Nationality Act (INA).

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.2.14. The J-1 physician and his/her employer must, on commencement of practice and annually thereafter through the contract period, verify the physician’s practice site address and field of practice. The reporting can be submitted on the “J-1 Visa Physician Verification of Employment Form” contained in this application packet. The first report must be submitted within 30 days. For population based HPSAs, documentation that the population the foreign physician was placed there to serve was indeed served must be maintained. The final report must indicate whether the J-1 physician intends to remain in the shortage area to practice. Failure to submit accurate reports in a timely manner that complies with the Mississippi Conrad State 30 J-1 Visa Waiver Guidelines will jeopardize future eligibility for J-1 Visa physician placements.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.2.15. [RESERVED]

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.2.17. [RESERVED]

Rule 1.2.18. The Mississippi Conrad State 30 J-1 Visa Waiver Program will consider requests

for recommendations of specialists and placement of J-1 physicians at facilities not located in a HPSA designated area (provided the facility is serving patients from a nearby HPSA designated area) in accordance with current federal guidelines regarding FLEX slots.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.2.19. Facilities not located in a HPSA must have at least 30% of their patients from the nearby HPSA(s) qualifying the application. The facility must submit in the Mississippi Conrad State 30 J-1 Visa Waiver Application the facility's patient origin data (by county) for the previous calendar year.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.2.20. [RESERVED]

Rule 1.2.21. [RESERVED]

Rule 1.2.22. [RESERVED]

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.2.23. [RESERVED]

Rule 1.2.24. [RESERVED]

Rule 1.2.25. [RESERVED]

SOURCE: Miss. Code Ann. §41-3-17

Subchapter 3. EMPLOYMENT CONTRACT:

Rule 1.3.1. The J-1 physician is responsible for locating and negotiating a contract for a minimum of three (3) years and preferably four (4) years (unless the service requirement is amended) to provide care a minimum of 40 hours per week, as a primary care physician or psychiatrist in a federally designated HPSA in Mississippi. The 40 hours must be performed during normal office hours, or hours which best suit the needs of the community and may not be performed in less than four (4) days a week. A weekly schedule must be included in all waiver requests. It is recommended that each party have its own legal representation in preparation of the contract.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.3.2. The J-1 physician must be board eligible in his/her field of practice and eligible for Mississippi licensure.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.3.3. By regulation (Immigration and Nationality Act, as amended, section 214(k)(1)

[8U.S.C. (1184 (k)(1)]), the J-1 physician must commence practice within 90 days of receiving a waiver.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.3.4. The J-1 Visa physician must agree in writing that he or she will begin employment within 90 days of receiving a waiver; and a statement from the J-1 Visa physician regarding planned commitment to the community should be provided.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.3.5. The Department of State and INS will be notified if a J-1 physician is found not to have reported or not be practicing medicine a minimum of 40 hours per week in the location for which the recommendation was made.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.3.6. MSDH must be notified when the J-1 physician does not report for duty or leaves the practice site for whatever reason.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.3.7. The employer and/or J-1 physician must notify MSDH of breach or termination of contract.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.3.8. For the statutorily required period there can be no changes to the contract that would result in the J-1 physician leaving the agreed-upon site and no longer treating the patients he/she has agreed to treat in the manner agreed upon unless the physician has petitioned the United States Citizen and Immigration Services.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.3.9. The contract should not state commencement or expiration dates. It is a tentative contract based on the application being approved through MSDH, U.S. Department of State and INS.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.3.10. A non-competition clause or any provision that purports to limit the J-1 physician's ability to remain in the area upon completion of the contract term is prohibited by regulation.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.3.11. The contract may include a liquidation clause but is not required by MSDH. However, any clauses that would require the J-1 physician to pay a sum to the employer for experience gained on the job or for the J-1 physician remaining in

the area after the contract has ended are not allowed.

1. Include in all employment contracts the following information:
   a. guaranteed 3-year base salary
   b. benefits
   c. insurance
   d. field of practice, practice site name and address for 40 hours for at least 4 days per week, not including travel and on-call time; days and hours on site, if multiple sites
   e. leave (annual, sick, continuing medical education, holidays)
   f. commencement date begins within 90 days of receipt of J-1 visa waiver
   g. statement that amendments shall adhere to State and Federal J-1 visa waiver requirements

SOURCE: Miss. Code Ann. §41-3-17

Subchapter 4. RECRUITMENT:

Rule 1.4.1. The medical facility must provide evidence that other avenues, regionally and nationally, to secure a physician not bound by the 2-year home residence requirement have been undertaken over a period of at least three (3) months. The recruitment effort must have occurred prior to submission of the Mississippi Conrad State 30 J-1 Visa Waiver Application.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.4.2. Recruitment information must state the position available and the practice site location. Ads must contain date information that can be used to verify at least three (3) months of recruitment effort and regional and national reach.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.4.3. Ads run at the time of or after submission of the Mississippi Conrad State 30 J-1 Visa Waiver Application are not usable.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.4.4. Documentation of recruitment efforts may include:

1. Copies of the regional and/or national print advertising ads (copies of ads must show publication date).
2. Online ads (ads must show the date the ad was online).

3. Copies of certified letters to medical schools.

4. Other forms of recruitment documentation will be reviewed to determine if information for the specific position requested in the Mississippi Conrad State 30 J-1 Visa Waiver Application is clearly identified and to determine if sufficient date information is available to verify three (3) months of recruitment effort.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.4.5. [RESERVED]

Rule 1.4.6. The sponsoring health care facility is required to publish a legal notice in their local newspaper of general circulation in accordance with the following format in Rule 1.4.7. through Rule 1.4.9. The Proof of Publication of this notice must be submitted with the Mississippi Conrad State 30 J-1 Visa Waiver Application.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.4.7. (Name of J-1 sponsoring facility and complete mailing address) is requesting that the Mississippi State Department of Health support a J-1 Visa waiver of the two-year foreign residency requirement of (physician name) in exchange for (Primary Care or Specialty Care) health services to (name of underserved area), an underserved area of the state, if approved by the U.S. Department of State.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.4.8. Letters of support or opposition may be sent to the Director, Office of Rural Health and Primary Care, Mississippi State Department of Health, P.O. Box 1700, Jackson, MS 39215-1700. Any interested party has 21 calendar days from the date of this publication to submit letters.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.4.9. Copies of letters may be obtained from the Office of Rural Health and Primary Care at the Mississippi State Department of Health.

SOURCE: Miss. Code Ann. §41-3-17

Subchapter 5. PROHIBITIONS:

Rule 1.5.1. MSDH will not consider recommendations when the provisions of Subchapter 2 have not been met and under the following circumstances:

1. Preliminary determinations over the telephone prior to final review of the Mississippi Conrad State 30 J-1 Visa Waiver Application being completed.

2. Medical facilities located in those counties which are a part of the Appalachian Regional Commission are not eligible to recruit primary care J-1 Visa physicians through the Program. These facilities can recruit psychiatrists and specialists through this Program.

3. Requests from areas/populations that have become fully served due to sufficient placement of physicians, unless a previously recommended J-1 physician has left the area or for replacement of local physicians who have discontinued practice in a designated area. Exceptional circumstances will be reviewed on a case-by-case basis.

4. More than two (2) Mississippi Conrad State 30 J-1 Visa Waiver Applications per employer each federal fiscal year. Exceptional circumstances will be reviewed on a case-by-case basis (depending on the number of remaining waivers and unmet needs in community and state).

5. Requests for a J-1 physician whose last Certificate of Eligibility for Exchange Visitor status has expired more than 210 days prior to the time the Mississippi Conrad State 30 J-1 Visa Waiver Application request is submitted.

6. Requests from an employer who is a former J-1 physician currently fulfilling his/her required 3-year obligation.

7. A waiver for a relative or acquaintance of the employer.

8. Failure to comply with Rule 1.2.16. *SOURCE:*

Miss. Code Ann. §41-3-17

Subchapter 6. TRANSFERS:

Rule 1.6.1. The J-1 Visa waiver physician must remain in employment for a total of not less than three (3) years, at the site(s) listed in the Mississippi Conrad State 30 J-1 Visa Waiver Application and for which the waiver is approved, unless the physician petitions the United States Citizen and Immigration Services for early termination of the 3-year period because the practice site closes of due to extenuating circumstances.

1. The J-1 Visa Waiver physician must notify the MSDH in writing as soon as possible of their intent to petition the United States Citizen and Immigration Services for early termination of the 3-year period because the practice site closes or due to extenuating circumstances.

2. To work at another facility the J-1 Visa Waiver physician must amend or file a new H-1B petition with the United States Citizen and Immigration Services.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.6.2. The J-1 physician retains sole responsibility for notifying their current employer of the intent to petition the United States Citizen and Immigration Services for early termination of the 3-year period, and payment of any financial penalty caused by a breach of contract.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.6.3. [RESERVED]

Rule 1.6.4. [RESERVED]

Rule 1.6.5. [RESERVED]

Rule 1.6.6. [RESERVED]

Rule 1.6.7. [RESERVED]

Rule 1.6.8. [RESERVED]

SOURCE: Miss. Code Ann. §41-3-17

Subchapter 7. FOREIGN PHYSICIANS RELEASED DUE TO TERMINATION, MUTUAL RELEASE, OR DEATH:

Rule 1.7.1. The Mississippi Office of Rural Health and Primary Care must be informed in writing by the sponsoring employer of the following circumstances:

1. the sponsoring employer determines that there is reasonable cause to terminate the employment contract of a foreign provider.

2. the employer and foreign provider mutually agree to the release from employment;

3. there are no funds to reimburse the foreign provider for their services; or

4. there is a loss due to the death of the foreign provider.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.7.2. Mississippi Office of Rural Health and Primary Care will assist, in a limited way, the sponsoring employer and foreign physician in resolving termination disputes. However, the Mississippi Office of Rural Health and Primary Care will assume no position in the dispute.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.7.3. Mississippi Office of Rural Health and Primary Care will assist, in a limited way, the foreign provider in securing another position in the state.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.7.4 J-1 Visa Waiver physicians who are released from the sponsoring medical facility prior to the completion of the federally required three (3) year full-time service obligation must amend or file a new H-1B petition with the United States Citizen and Immigration Services to complete the service obligation at another facility. The J-1 Visa Waiver physician must notify the MSDH that he/she is petitioning.

SOURCE: Miss. Code Ann. §41-3-17

Subchapter 8. NATIONAL INTEREST WAIVER (NIW) SUPPORT LETTERS:

Rule 1.8.1. Please refer to the Mississippi State Department of Health National Interest Waiver Guidelines for the requirements for consideration of a support letter for a NIW application.

SOURCE: Miss. Code Ann. §41-3-17

Title 15: Mississippi State Department of Health

Part 9: Office of Health Policy and Planning

Subpart 97: Policies and Procedures Manual

Chapter 1. MQHC Grant Program Overview

Rule 1.1.1. The Mississippi Qualified Health Center (MQHC) Grant Program was established during the 1999 Mississippi Legislative Session for the purpose of making service grants to Mississippi Qualified Health Centers for their use in providing care to uninsured or medically indigent patients in Mississippi.

SOURCE: Miss. Code Ann. §41-99-3

Rule 1.1.2. Reserved.

Rule 1.1.3. The program allows centers to use the funds to (a) increase access to preventative and primary care services by uninsured or medically indigent patients that are served by the centers; and (b) to create new services or augment existing services provided to uninsured or medically indigent patients, including, but not limited to, primary care medical and preventive services, dental services, optometric services, in-house laboratory services, diagnostic services, pharmacy services, nutritional services, and social services.

SOURCE: Miss. Code Ann. §41-99-5

Rule 1.1.4. Pursuant to Mississippi Code §41-99-5(3) funds received through the MQHC Grant Program cannot be used for the following:

To supplant federal funds traditionally received by those centers, but can be used to supplement them; or

For land or real estate investments; or

To finance or satisfy any existing debt.

SOURCE: Miss. Code Ann. §41-99-5

Rule 1.1.5. Mississippi Code §41-99-3 specifies that the Mississippi State Department of Health (MSDH) shall administer the MQHC Grant Program.

SOURCE: Miss. Code Ann. §41-99-3

Rule 1.1.6. As set forth in Mississippi Code §41-99-5 (5) (b), the maximum grant award to a Mississippi Qualified Health Center is $200,000 per state fiscal year.

SOURCE: Miss. Code Ann. §41-99-5

Rule 1.1.7. A Request for Proposal process will be used to award MQHC grants during the first year of a legislative authorized period.

SOURCE: Miss. Code Ann. §41-99-5

Rule 1.1.8. Reserved.

Rule 1.1.9. Reserved.

Chapter 2. MQHC Grant Program Advisory Council

Rule 2.1.1. Pursuant to Mississippi Code § 41-99-5(6), the MSDH is required to establish an advisory council to review and make recommendations to the MSDH on the awarding of any grants to Mississippi Qualified Health Centers.

SOURCE: Miss. Code Ann. §41-99-5

Subchapter 2. Advisory Council Membership

Rule 2.2.1. In accordance with 41-99-5(7), the advisory council membership consists of the following:

Two (2) employees of the MSDH, one (1) of whom must have experience in reviewing and writing grant proposals;

Two (2) executive employees of Mississippi Qualified Health Centers, one (1) of whom must be a chief financial officer;

Two (2) health care providers who are affiliated with a Mississippi Qualified Health Center; and

One (1) health care provider who is not affiliated with a Mississippi Qualified Health Center nor the MSDH, but has training and experience in primary care.

SOURCE: Miss. Code Ann. §41-99-5

Rule 2.2.2. To help ensure that the council has broad representation and a sufficient number of members to review proposals, centers are limited to having only one representative serve on the council at a time.

SOURCE: Miss. Code Ann. §41-99-5

Rule 2.2.3. The advisory council appointments will be for a two-year term.

SOURCE: Miss. Code Ann. §41-99-5

Rule 2.2.4. Reserved.

Rule 2.2.5. Reserved.

Rule 2.3.1. There shall be the following officers for the advisory council:

Chairperson
Vice-Chairperson

SOURCE: Miss. Code Ann. §41-99-5

Rule 2.3.2. The Chairperson shall chair the council meetings. The Vice-Chairperson shall exercise the duties of the Chairperson in his/her absence.

SOURCE: Miss. Code Ann. §41-99-5

Subchapter 4. Advisory Council Governing Policies

Rule 2.4.1. The advisory council shall meet to vote on their recommendation for each grantee's award.

Rule 2.4.2. Reserved.

Rule 2.4.3. Reserved.

Rule 2.4.4. Reserved.

Rule 2.4.5. Reserved.

Rule 2.4.6. Reserved.

Subchapter 5. Advisory Council Agenda

Rule 2.5.1. MQHC staff shall provide council members with the meeting agenda.

SOURCE: Miss. Code Ann. §41-99-5

Rule 2.5.2. Reserved.

Rule 2.5.3. Reserved.

Rule 2.5.4. Reserved.

Chapter 3. Advisory Council Members' Voting

Rule 3.1.1. In order for the advisory council to conduct official business a quorum of five (5)

members must be present.

SOURCE: Miss. Code Ann. §41-99-5

Rule 3.1.2. A member present may vote for or against any motion, or the member may abstain. Voting by proxy is not permitted.

SOURCE: Miss. Code Ann. §41-99-5

Rule 3.1.3. The minutes of the advisory council shall reflect the vote on each matter. A unanimous vote may be reflected.

SOURCE: Miss. Code Ann. §41-99-5

Rule 3.1.4. Advisory council members cannot review the proposal or Funding Continuation Application for the facility where they are employed.

SOURCE: Miss. Code Ann. §41-99-5

Subchapter 2. Advisory Council Minutes

Rule 3.2.1. The minutes of the advisory council shall be the responsibility of the MQHC Program Coordinator. Minutes shall become official upon approval by the advisory council. Approved minutes will be on file at the Mississippi State Department of Health.

SOURCE: Miss. Code Ann. §41-99-5

Subchapter 3. Advisory Council Members Expenses

Rule 3.3.1. Pursuant to Mississippi Code § 41-99-5(8), the MSDH may use a portion of any grant monies appropriated for the MQHC Grant Program for administration of the program and to pay reasonable expenses incurred by the advisory council. Council members shall be reimbursed for reasonable expenses in accordance with current MSDH finance policies.

SOURCE: Miss. Code Ann. §41-99-5

Chapter 4. MQHC Grant Program Request For Proposals

Subchapter 1. Guidelines And Procedures

Rule 4.1.1. Pursuant to Section 4 of Mississippi Code § 41-99-5, the MSDH has developed a process to allow Mississippi Qualified Health Centers to apply for a grant under the MQHC Grant Program. MQHCs may apply for new funding in the first state fiscal year of each legislatively authorized program period. A Funding Continuation process will be utilized to award grants for the remaining four fiscal years of the program period.

SOURCE: Miss. Code Ann. §41-99-5

Rule 4.1.2. The MSDH has developed the following procedures and criteria for accepting grant proposals from Mississippi Qualified Health Centers and for making funding recommendations for the first state fiscal year of the legislatively authorized program period for the MQHC Grant Program.

SOURCE: Miss. Code Ann. §41-99-5

Subchapter 2. MQHC Grant Program Award Allocation for Grantees

Rule 4.2.1. The MQHC Grant Program Award Allocation will be distributed equitably among grantees, based on evaluation criteria, activities undertaken, and performance measures (the award per grantee, per state fiscal year, is limited to $200,000). To ensure that all awarded funds will be utilized for legislatively intended purposes, centers must submit an acceptable MQHC Grant Program Proposal/Funding Continuation Application.

SOURCE: Miss. Code Ann. §41-99-5

Subchapter 3. MQHC Grant Program Redistribution of Awards

Rule 4.3.1. MQHC Grant Program funds allotted for a Mississippi Qualified Health Center that does not meet requirements of the program will be redistributed proportionately among the remaining grantees. The percent that the initial grant award represents of the total MQHC Grant Program Award Allocation will be applied to determine the amount of additional funds that the remaining grantees will be eligible to receive. In no case shall the maximum award amount per grantee per state fiscal year exceed ten percent (10%) of available funds per calendar year.

SOURCE: Miss. Code Ann. §41-99-5

Rule 4.3.2. When funds are available to be redistributed, the MSDH will provide written notification of the Availability of Redistributed Funds to the Executive Directors of funded centers and to the Executive Director of the Mississippi Primary Health Care Association. Grantees must submit information required by the MSDH regarding the utilization of the additional funds to the Office of Primary Care Liaison within thirty (30) calendar days of the date of the Notice of Availability of Redistributed Funds. Grantees not submitting the required information will not be eligible to receive any of the funds available for redistribution.

SOURCE: Miss. Code Ann. §41-99-5

Subchapter 4. MQHC Grant Program Request for Proposals

Rule 4.4.1. The MQHC Grant Program Request for Proposals has been designed to help centers apply for MQHC Grant Program funding. The Request for Proposals provides guidance for developing a proposal that explains all requirements.

SOURCE: Miss. Code Ann. §41-99-5

Rule 4.4.2. The Request for Proposals contains the following items:

Grant period;

Eligible applicants;

Amount of funds available;

Source of funds to be awarded;

Information regarding applicable laws and regulations;

Funding objectives and areas of special emphasis or interest;

Recipient financial participation requirements, e.g. matching or cost sharing requirements;

Proposal format, including deadline date and time for receipt of proposals;

Criteria for review and evaluation and program priorities for funding; and

The number of originals and copies of the proposal to submit.

SOURCE: Miss. Code Ann. §41-99-5

Rule 4.4.3. Proposals for the MQHC Grant Program must be submitted in the manner prescribed by the MSDH. Applicants should read the RFP guidelines thoroughly and follow all directions. Applicants are encouraged to attend the MQHC Grant Program Request for Proposals Workshop. The MSDH may also be contacted for assistance.

SOURCE: Miss. Code Ann. §41-99-5

Subchapter 5. MQHC Grant Program Request for Proposals Workshop

Rule 4.5.1. The Mississippi Department of Health will conduct one Request for Proposals workshop during the last state fiscal year of the legislatively authorized program period to provide information regarding the submission and requirements of the MQHC Grant Proposal.

SOURCE: Miss. Code Ann. §41-99-5

Subchapter 6. MQHC Grant Program Proposal Submission/Review/Award Process

Rule 4.6.1. Eligible Applicants: Mississippi Qualified Health Centers are eligible to submit an application for MQHC funding to the MSDH.

SOURCE: Miss. Code Ann. §41-99-5

Rule 4.6.2. MQHC Grant Program Proposals Submission Date Proposals requesting funding under the Mississippi Qualified Health Center Grant Program are due in the MSDH, Office of Primary Care Liaison, by 5:00 p.m. on January 15th of the last state fiscal year of the current legislatively authorized program period for the MQHC Grant Program. Acceptance of proposals at this time will be in anticipation of the Mississippi Legislature re-authorizing the MQHC Grant Program.

This submission date will allow the MSDH and the MQHC Grant Program Advisory Council to complete the RFP process and should allow grantees to begin implementation of their new approved MQHC Grant projects on July 1st (which would be the first day of the first state fiscal year for the re-authorized program period).

Proposals are due by the submission deadline. The Office of Primary Care has the option to return late proposals or accept with or without penalty to the late applicant.

Acceptance of a Mississippi Qualified Health Center Grant Program proposal/ application does not obligate the MSDH to award a grant to the applicant.

SOURCE: Miss. Code Ann. §41-99-5

Rule 4.6.3. Minimum Requirements for Proposals to be Considered

MQHC Grant Program Applications must meet the following minimum requirements in order to be considered:

Submission of an acceptable independent audit report for the applicant's most recent fiscal year or the most recent audit according to the United States Department of Health and Human Services, Health Resources & Services Administration (HRSA) guidelines.

Submission of the applicant's complete MQHC Grant Program Closeout Package (two copies required) for the last state fiscal year ended for which the applicant was funded.

Submission of a copy of applicant's sliding-fee schedule for payments.

Submission of the six-month progress report for last year funded.

Submission of a complete proposal in the described format indicated in the instructions.

Certification that the applicant has an adopted policy regarding non-discrimination pursuant to Section 9 of Mississippi Code § 41-99-5.

Certification that the applicant has an adopted policy regarding non-refusal of services pursuant to Mississippi Code § 41-99-1 (a) (ii).

Applicant must have no unresolved monitoring findings.

Applicants not meeting the minimum requirements for their proposals to be considered will

be notified in writing and provided thirty (30) calendar days from the date of the notice to submit the required items to the MSDH, Office of Primary Care Liaison. If the required information is not received within this time frame, the proposal will not be eligible for review.

SOURCE: Miss. Code Ann. §41-99-5

Rule 4.6.4. MQHC Grant Program Proposal Review/Award Process

The MSDH may contact applicants for clarification of information presented in the proposal. The proposal review process is as follows:

The proposal will be reviewed by MSDH staff to determine if it meets the minimum requirements for consideration (including being received by the due date).

Proposals meeting minimum requirements for consideration will be reviewed and scored by two separate review committees (scoring will be based on pre- established evaluation criteria). One committee will be comprised of MSDH staff and the other comprised of the MQHC Grant Program Advisory Council. The two scores obtained from the independent reviews will be averaged for the proposal's final score. A minimum score of seventy (70) is required to be considered for funding.

The review committees will be informed of the applicants that did not meet the minimum requirements to be considered.

The Advisory Council will meet to vote on the recommendation to make to the MSDH regarding the awarding of grants to centers under the MQHC Grant Program.

The MSDH is not bound by the recommendation of the Advisory Council. When the MSDH does not follow the recommendation of the Advisory Council on the awarding of a grant, an appeal process is afforded applicants (refer to PART III, Section 3-6 (F) MQHC Grant Program Applicant Appeal Process).

If the MSDH does not accept the Advisory Council's recommendation regarding the awarding of a grant to a center under the MQHC Grant Program, the MSDH will provide a written statement to the Advisory Council detailing the reason(s) for not accepting the Advisory Council's recommendation.

Applicants will be notified in writing of the funding decision.

SOURCE: Miss. Code Ann. §41-99-5

Rule 4.6.5. MQHC Grant Program Applicant Appeal Process

This appeal process is only applicable when the MSDH does not follow the recommendation of the Advisory Council on the awarding of a grant to a center under the MQHC Grant Program. The appeal process shall proceed as follows:

The applicant must submit a written correspondence to the MSDH, Office of Primary Care Liaison (return receipt requested) indicating that the applicant would like to appeal the MSDH's decision. The correspondence must also state why the applicant believes the decision should be reconsidered. The applicant's appeal correspondence must be received in the Office of Primary Care Liaison within thirty (30) calendar days of the date of the applicant's grant denial letter.

The State Health Officer or his designee will be notified of the MQHC Grant Program applicant's request for an appeal.

The State Health Officer or his designee may meet with the Advisory Council and the applicant for discussion of the applicant's appeal request. Only the original information submitted in the proposal/application may be utilized for discussion. The State Health Officer or his designee will make a decision regarding funding. This decision shall be final.

The applicant will be notified in writing within thirty (30) calendar days of the date that the decision is made.

SOURCE: Miss. Code Ann. §41-99-5

Chapter 5. MQHC Grant Program

Subchapter 1. Request for Funding Continuation

Rule 5.1.1. After the grant awards are made for the first state fiscal year of the legislatively authorized program period, Mississippi Qualified Health Centers must submit a Funding Continuation (FC) Application to request funding.

SOURCE: Miss. Code Ann. §41-99-5

Subchapter 2. Reserved.

Rule 5.2.1. [Reserved.]

Subchapter 3. MQHC Grant Program Funding Continuation Submission/ Review/Award Process

Rule 5.3.1. The MSDH will prepare a MQHC Grant Program Funding Continuation Application Announcement for submission to the MQHCs. The announcement will provide the application and indicate when due.

SOURCE: Miss. Code Ann. §41-99-5

Rule 5.3.2. To ensure a timely start of MQHC grantee projects, the Funding Continuation Application must be submitted to the MSDH by the deadline identified in the Funding Continuation Announcement to ensure that applications can be reviewed, awards recommendations made by the advisory council, and submission of the council's recommendation to the MSDH.

SOURCE: Miss. Code Ann. §41-99-5

Rule 5.3.3. The Funding Continuation Application must meet the minimum requirements listed in Rule 4.6.3 and in the Funding Continuation Application Announcement.

SOURCE: Miss. Code Ann. §41-99-5

Rule 5.3.4. The Funding Continuation Application will be reviewed to determine if it meets the minimum requirements.

SOURCE: Miss. Code Ann. §41-99-5

Rule 5.3.5. The MSDH may contact applicants for clarification of information presented in the Funding Continuation Application.

SOURCE: Miss. Code Ann. §41-99-5

Rule 5.3.6. Acceptance of a Funding Continuation Application does not obligate the MSDH to award a grant to the applicant.

SOURCE: Miss. Code Ann. §41-99-5

Rule 5.3.7. The MQHC advisory council will meet to vote on the recommended award for each qualifying applicant.

SOURCE: Miss. Code Ann. §41-99-5

Rule 5.3.8. The MQHC advisory council recommendations will be presented to the MSDH.

SOURCE: Miss. Code Ann. §41-99-5

Rule 5.3.9. The MSDH is not bound by the recommendation of the advisory council. When the MSDH does not follow the recommendation of the advisory council on the awarding of a grant, the MSDH will place in its minutes reasons for not accepting the advisory council's recommendations and will inform the applicant of the availability of an appeals process.

SOURCE: Miss. Code Ann. §41-99-5

Chapter 6. Implementation of MQHC Grant Program Projects

The following guidelines have been designed to ensure compliance with state requirements and to provide instructions to help grantees successfully implement MQHC Grant Program projects.

Subchapter 1. MQHC Grant Program Award Notices

Rule 6.1.1. Grantees will be provided written notices of their approved grant award.

SOURCE: Miss. Code Ann. §41-99-5

Subchapter 2. MQHC Grant Program Contract Agreements

Rule 6.2.1. A MSDH contract agreement will be executed between the MSDH and the grantee for the approved award amount. All grant funds are based on availability of funding.

SOURCE: Miss. Code Ann. §41-99-5

Rule 6.2.2. Funds will be approved for payment in a manner to ensure that should state budget cuts be required funds will be available to institute the cuts.

SOURCE: Miss. Code Ann. §41-99-5

Rule 6.2.3. Reserved.

Rule 6.2.4. Reserved.

Subchapter 3. Finance

Rule 6.3.1. *Centers must use appropriate fiscal controls and accounting procedures to ensure accountability of grant funds.*

SOURCE: Miss. Code Ann. §41-99-5

Rule 6.3.2. MQHC Grantees may use the following budget line items: personnel, fringe benefits, travel, equipment, supplies, contractual, other, and indirect costs (definitions will be provided in the Request for Proposals and Funding Continuation Application instructions).

SOURCE: Miss. Code Ann. §41-99-5

Rule 6.3.3. Requesting Grant Funds

The following applies for requesting payment of MQHC Grant Program funds:

Grantees are to request payment of MQHC Grant Program funds on a monthly basis.

MQHC Grant Program Payment Request Sheets along with supportive documentation must be submitted when requesting payment.

A cover letter requesting the monthly payment signed by the Chief Executive Officer of the center must be submitted with each individual monthly payment request. The letter must be on the grantee's letterhead and must indicate the state fiscal year of the grant, the month for which payment is being requested, and the amount being requested.

No payment request will be approved for grantees with unresolved MQHC Grant Program monitoring findings until the findings are resolved. Grantees must adhere to the following procedure when requesting payment of grant MQHC Grant funds.

Requests for payments cannot be processed prior to MSDH's approval of a MQHC contract agreement between the MSDH and the Mississippi Qualified Health Center. Payments will only be approved for activities for the contract period.

Requests for payments cannot exceed the contract amount.

The final payments requests must be submitted to the MSDH no later than thirty (30) days after the end date of the contract. The contract period will be listed on the contract. Failure to submit the final payment request and all required supportive documentation by this deadline may result in the MSDH not being able to process the payment request through our finance department.

Grantees are submit payment requests to the MSDH by the 15th day of the month immediately following the month for which the request is being made (for example, the payment request for the month of October should be received at the MSDH by November 15th).

Incomplete and or incorrect payment requests submitted by grantees will not be approved for payment until all deficiencies are corrected. MSDH MQHC Grant program staff will notify grantees when payment requests are incomplete and or incorrect and provide assistance.

Once payment requests are approved by the MSDH Primary Care Office, the payment request is submitted to the MSDH, Office of Finance.

SOURCE: Miss. Code Ann. §41-99-5

Rule 6.3.4. Supportive Documentation Information

Acceptable forms of supportive documentation to be submitted with payment requests include the following at a minimum:

Personnel: Copies of payroll ledgers, payroll registers, payroll journals, or payroll check stubs must be submitted as supportive documentation when requesting payment for the personnel budget category. Documentation must indicate staff person's name, date of payroll, and payroll amount.

Payment will only be allowed for the staff positions and personnel listed in the approved project budget. The MSDH must be notified of any personnel changes in order for payment to be approved.

Grantees wanting to add a staff position(s) not listed in the approved budget must submit a written correspondence to the MSDH regarding the change, and must justify why an additional staff position(s) is warranted. If adding a new staff position requires adjusting the budget, a MQHC Grant Program Budget Modification Sheet must also be submitted.

Fringe Benefits: Documentation for fringe benefits can be verified by information on pay stubs.

Travel: MQHC Grant Program Travel Sheet, along with proof of travel, hotel billing, registration forms and agendas, must be submitted as documentation for the travel budget category.

Equipment and Supplies: Invoices and receipts are acceptable forms of supportive documentation for equipment and supplies (invoice or receipt must provide billing organization's name, date, listing of items purchased, and amount(s)). All invoices must be billed to grantee.

Contractual: Invoices, receipts, and billing statements may be submitted as documentation for payment request for the contractual items (all documentation must clearly identify the grantee, include date information, billing organization's name, listing or description of services or products provided, and amount(s).

Rule 6.3.5. Contract Budget Modifications

Grantees are allowed to request approval to modify their MQHC Grant program project budget. The budget line items for fringe benefits and indirect costs will not be approved in excess of the maximum percentages allowed by the MSDH. Grantees are required to submit the MQHC Grant Program Budget Modification Packet to the MSDH and obtain approval.

MQHC Grantees will be notified in writing by the MSDH of the approval or denial of the MQHC project budget modification request.

SOURCE: Miss. Code Ann. §41-99-5

Subchapter 4. MQHC Grant Program Recordkeeping Requirement

Rule 6.4.1. Grantees shall maintain financial and other records in accordance with the Financial Records and Audits requirements of the MQHC Grant Program contract agreement.

SOURCE: Miss. Code Ann. §41-99-5

Subchapter 5. MQHC Grant Program Monitoring

Rule 6.5.1. The MSDH has developed a monitoring policy to adhere to the requirement of Mississippi Code §41-99-5(4), which requires that the MSDH develop an audit

process to assure that grant monies are used to provide and expand care to the uninsured and medically indigent.

SOURCE: Miss. Code Ann. §41-99-5

Rule 6.5.2. Reserved.

Rule 6.5.3. Reserved.

Rule 6.5.4. The MSDH will conduct at least one on-site monitoring visit per state fiscal year to one-half of the grantees. The other half of the grantees will have their on-site monitoring visit the next state fiscal year. However an on-site visit for any grantee of the MQHC Grant Program may be conducted if it is considered necessary.

SOURCE: Miss. Code Ann. §41-99-5

Rule 6.5.5. During the monitoring site visit, activities related to implementation of the approved MQHC Grant project will be verified, grantees' progress will be assessed, and technical assistance will be available.

SOURCE: Miss. Code Ann. §41-99-5

Rule 6.5.6. Grantees will be notified in writing of the results of the monitoring site visit, of any monitoring findings, and the requirements of corrective actions if any required.

SOURCE: Miss. Code Ann. §41-99-5

Rule 6.5.7. Grantees are required to submit a corrective action plan to the MSDH by the due date indicated. The corrective action plan must include a timeline.

SOURCE: Miss. Code Ann. §41-99-5

Rule 6.5.8. If necessary, the MSDH will conduct follow-up site visits to verify correction of monitoring findings.

SOURCE: Miss. Code Ann. §41-99-5

Rule 6.5.9. Reserved.

Subchapter 6. MQHC Grant Program Project Closeout Reports

Rule 6.6.1. Mississippi Code §41-99-5 (5) (c) requires each grantee to submit a yearly report to the MSDH detailing the number of additional uninsured and medically indigent patients cared for, and the types of services provided. The MSDH has developed a Mississippi Qualified Health Center Grant Program closeout report to meet this legislative directive.

SOURCE: Miss. Code Ann. §41-99-5

Rule 6.6.2. Information tracking mechanisms should be established at the beginning of the grant period to ensure that project related information is accurate and can be captured throughout each grant budget cycle.

SOURCE: Miss. Code Ann. §41-99-5

Rule 6.6.3. Reserved.

Rule 6.6.4. The MSDH will provide grantees with the MQHC Grant Program closeout report.

SOURCE: Miss. Code Ann. §41-99-5

Rule 6.6.5. Reserved.

Rule 6.6.6. Reserved.

Title 15: Mississippi State Department of Health Part

9: Office of Health Policy and Planning

Subpart 98: Mississippi State Department of Health National Interest Waiver Guidelines

Chapter 1. MISSISSIPPI STATE DEPARTMENT OF HEALTH NATIONAL INTEREST WAIVER GUIDELINES

Rule 1.1.1. The employment based second-preference Worker Visa Preference Category (EB-2) allows individuals of exceptional ability and individuals who are members of professions holding advanced degrees to obtain a green card (United States permanent residence). For EB-2s a job offer and a labor certification is generally required. This requirement can be waived if the petitioner demonstrates to the United States Citizen and Immigration Services (USCIS) that granting the EB-2 petition would be in the national interest of the United States. The Physician National Interest Waiver (NIW) may be granted by the USCIS to a physician that agrees to work for a period of five (5) years in a

designated underserved area.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.1.2. Designated underserved areas include: Health Professional Shortage Area (HPSA), Medically Underserved Area (MUA), or Physician Scarcity Area (PSA) for specialist.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.1.3. The Office of the State Health Officer maintains the responsibility within the state of recommending and processing, through its Mississippi Office of Rural Health and Primary Care, NIW requests.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.1.4. A NIW support letter will not be considered when circumstances indicate that a foreign physician has violated any required service obligation (including failure to provide health care services in underserved areas or to residents of underserved areas, failure to work full-time, or leaving or transferring from a work site without petitioning the USCIS).

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.1.5 A non-refundable application fee of $1,200 is required in exchange for a complete review of a National Interest Waiver application and a NIW support letter from MSDH. A check or money order from the sponsoring facility should be made payable to the Mississippi State Department of Health with a note that the payment is for the “Waiver Application Review Fee” and submitted with the complete National Interest Waiver Application. No complete National Interest

Waiver Application will be processed without payment of the processing fee.

SOURCE: Miss. Code Ann. §41-3-17

Subchapter 2. FEDERAL ELIGIBILITY CRITERIA:

Rule 1.2.1. Physician must agree to work full-time in a clinical practice for a period of five (5) years.

1. Physician must work in primary care (such as a general practitioner, family practitioner, general internist, pediatrician, obstetrician/gynecologist, or psychiatrist) or be a specialty physician.
2. Physician must serve either in a currently designated Health Professional Shortage Area (HPSA), Medically Underserved Area (MUA), or for specialists, in a Physician Scarcity Area (PSA).
3. Physician must obtain a statement from a federal agency or a state department of health that has knowledge of the physician's qualifications and states that the physician's work is in the public interest.

SOURCE: Miss. Code Ann. §41-3-17

Subchapter 3. REQUIREMENTS TO REQUEST NIW SUPPORT LETTER FROM MISSISSIPPI STATE DEPARTMENT OF HEALTH:

Rule 1.3.1. A request for a NIW support letter will not be considered if any of the provisions in Rule 1.2.1. (1 and 2) are not met.

SOURCE: Miss. Code Ann. §41-3-17

Rule 1.3.2. Requests for NIW support letters must include the following in the order listed:

1. A letter from the sponsoring medical facility indicating:
   a. That the sponsoring medical facility is supporting a NIW application and is requesting a support letter from the Mississippi State Department of Health.
   b. The name of the proposed physician, medical discipline, and information on physician's qualifications.
   c. The name and location (complete street address, 9-digit zip code, and county) of the practice site(s) where the proposed physician will complete the five (5) year full-time clinical practice service obligation.
   d. The name of the currently designated Health Professional Shortage Area (HPSA), Medically Underserved Area (MUA), or Physician Scarcity Area (PSA) for specialist, where the proposed physician will serve.
   e. A description of the public benefit to the community that approval of the NIW will provide.
2. Copy of notarized, dated, executed employment contract to meet the five (5) year full-time employment service obligation required by the NIW regulations.
3. A letter of support from the current or previous employer of the physician or from a health care professional who has knowledge of the physician's qualifications.

4. The Mississippi State Department of Health NIW Sponsoring Medical Facility Information Form.

5. The Mississippi State Department of Health NIW Physician Information Form.

6. The Mississippi State Department of Health NIW Practice Site Information Form.

7. A letter from the sponsoring medical facility indicating that the organization: 1) understands that the NIW requires the physician to meet a five (5) year full-time clinical practice service obligation; and 2) that the organization agrees to submit the annual MSDH NIW Physician Employment Verification Form.

8. A letter from the applying physician indicating that the physician: 1) agrees to meet the requirement of the NIW of a five (5) year full-time clinical practice service obligation; and 2) agrees to submit the annual MSDH NIW Physician Employment Verification Form.

9. If the physician seeking the NIW support letter currently has a waiver from the two- year home residence requirement and has not completed the waiver's three (3) year full-time federal and contractual service obligation, the physician and the NIW sponsoring medical facility must both submit individual letters indicating that they understand and agree that the a physician must meet the waiver's three (3) year full- time federal and contractual service obligation of the employment contract entered, as PL 106-95 does not change the physician's obligation of the waiver contract terms. The letters must include the start and ending dates of the waiver service obligation period.

10. Physician's Curriculum Vitae.

11. Copy of a passport-style photo of physician.

12. Copy of physician's medical degree.

13. Proof of physician's passage of United States Medical Licensing Examinations (USMLE 3 Steps).

14. Copy of physician's Educational Commission for Foreign Medical Graduates Certificate.

15. Documentation of proposed physician's Board Certification or Board eligibility.

SOURCE: Miss. Code Ann. §41-3-17

Title 15: Mississippi State Department of Health

Part 9: Office of Health Policy and Planning

Subpart 99: MISSISSIPPI STATE RURAL HEALTH PLAN

Chapter 1. MISSISSIPPI STATE RURAL HEALTH PLAN

Subchapter 1. INTRODUCTION AND PURPOSE OF PLAN

Rule 1.1.1 A Mississippi State Office of Rural Health Program (SORH) was authorized as a unit of the Mississippi State Department of Health during the 1990 session of the Mississippi State Legislature. The specific legislative authority for the SORH is contained in Mississippi statute at Section 41-3-15. This State Rural Health Plan was developed to meet the SORH's legislative duty related to developing and implementing plans, to provide a definition for rural areas in the state, and to define rural facilities. The federal Office of Rural Health Policy (ORHP) at the Health Resources and Services Administration also periodically requires states to develop State Rural Health Plans (SRHP) to guide program activities when seeking FLEX Program funding for assisting critical access hospitals (CAHs).

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.1.2 As the population ages, the need for health care services and workers will increase. This State Rural Health Plan was developed to review the rural health sector of our state. The plan was prepared in consultation with the Mississippi State Rural Health Plan Steering Committee. The committee was comprised of representation from: the Mississippi Hospital Association, Mississippi Association of Supervisors and other small rural hospitals.

SOURCE: Miss. Code Ann. § 41-3-15

Subchapter 2. STATE PROFILE

Rule 1.2.1 State Historic Information and Geographic Description- Mississippi is named for the Mississippi river which forms its western boundary and empties into the Gulf of Mexico. The name roughly translated from Native American folklore means "Father of Waters." Mississippi was organized as a territory in 1798 and was admitted as the 20th state to join the Union on December 10, 1817. David Holmes was chosen as the first governor of the state.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.2.2 Mississippi is bounded on the north by Tennessee, on the east by Alabama, on the west by Arkansas and Louisiana, and on the south by the Gulf of Mexico. Mississippi contains 47,715 square miles of area, mostly rural farmland. In the north, the large, fertile alluvial Delta was mostly swamp until the mid-1850s when, by the sweat of men and mules, some 300 miles of levees claimed this broad region.

At the Delta's eastern edge, the land suddenly changes from table- flat to the rising loess bluff hills, stretching north into Tennessee and south into Louisiana. From Mississippi's northeast hills southward, the land changes into rolling farmland, hardwood highlands, then red clay hills to fertile pasture lands, on to piney forest, eventually giving way to the man-made white sand beaches of the Gulf Coast.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.2.3 Population Distribution and Demographics- Mississippi has 82 counties and the U.S. Census Bureau's 2008-2012 American Community Survey Five-Year Estimate reported Mississippi's population at 2,967,620.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.2.4 Mississippi demographics include high poverty levels (22.3% compared to 14.9% for the nation), a large African American population (37.7%), low education levels, very limited industry in many rural areas, poor local tax bases, and diminishing state dollars. Rural residents and minorities are population groups affected by health disparities. According to the American Community Survey, the median age is 36 years and persons aged 65 or older makes up 12.9% of the population.
Mississippi's gender composition is 48.5% male and 51.5% female.
The poverty rate for the elderly was 14.6% compared to 9.4% is the nation. Eighty-one percent of Mississippians over the age of 25 are high school graduates or higher and 20% of Mississippians in this age group have a bachelor's degree or higher. Both levels are less than the respective national average at 85.7% and 28.5%.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.2.5 Mississippi Economic Data- The Census Bureau 3-Year Average (2011-2013) median household income (in 2013 inflation-adjusted dollars) for the nation was $52,517. Mississippi ranked 50th in this area with a median household of $40,194.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.2.6 The state had an average citizen labor force of 1,347,995 with an unemployment rate of 10.6%. During September 2014, eighteen counties reported double- digit unemployment rates. Thirty-five percent of the population had public health insurance coverage and 17.5% had no health insurance coverage.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.2.7 Health Status- Mississippi is traditionally a medically underserved state with statistics presenting an extremely negative view of the overall health of citizens in the state. Compared to national health data, Mississippi residents rank lowest in several overall health indicators. Some of the health problems of Mississippians are the result of behavioral risk factors for youths and adults, health disparities, lack of access, and an inadequate supply of health professionals for underserved areas.
These factors often lead to high morbidity and high mortality rates. Mississippi's rates for cardiovascular disease, diabetes, obesity, teenage pregnancy, premature

births, low birth weights, and infant mortality are some of the highest levels in the nation. Table 1 provides information on some of Mississippi's health indicators.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.2.8 Some of the state's health care priority areas include disease prevention, health promotion, health protection, healthcare for specific population groups (i.e., mothers, babies, the elderly, indigent, uninsured, the disabled, persons with developmental conditions, and minorities), availability of adequate health workforce throughout the state, health disparities, mental health needs, and enhanced capability to respond to public health emergencies.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.2.9 The prevalence of mental illness, although difficult to assess, serves as a good indicator of the volume of need for mental health services in a given population. The Mississippi Department of Mental Health's (MDMH) state fiscal year 2013 annual report, estimated that 165,000 people would need mental health services.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.2.10 The Health Resources and Services Administration (HRSA) has developed a listing of key health indicators that can be used to assess health status, identify barriers to access to care, and provide a quantitative measure of need. Table 1 provides a listing of indicators that present a snapshot of the barriers and health problems of the state of Mississippi as they compare to national data.

TABLE 1
Mississippi Core Health Indicators

Core Health Indicators	**Mississippi Data/Rate**	**US Data/Rate**
Diabetes Prevalence (diagnosed with diabetes) Source: http://apps.nccd.cdc.gov/BRFSS-	12.4%	8.7%
SMART/SelMMSAPrevData.asp		
Mortality Rate from Diseases of the Heart Source: http://wonder.cdc.gov	292.1	223.3
Women Age 50+ (No Mammogram in Past 2 Years) Source: http://apps.nccd.cdc.gov/BRFSS-SMART/SelMMSAPrevData.asp	28.9%	23%
Adults Who Are Current Smokers Source: http://apps.nccd.cdc.gov/BRFSS-SMART/SelMMSAPrevData.asp	24%	19.6%
Infant Mortality Rate per 1,000 Source: http://wonder.cdc.gov	10.53	6.68
Children With Obese Weight Status Based on Body Mass Index for Age 10-17 Source: http://childhealthdata.org/browse/survey	21.9%	16.4%

Suicide Rate (Crude Rate per 100,000) Source: CDC WONDER http://wonder.cdc.gov	13.1	12.4
Percentage of Adults Without A Visit to Dentist or Dental Clinic in Past Year Source: http://apps.nccd.cdc.gov/BRFSS-SMART/SelMMSAPrevData.asp	44.6%	32.8%

SOURCE: Miss. Code Ann. § 41-3-15

Subchapter 3. STATE RURAL AREA DEFINITION

Rule 1.3.1 The state defines a rural area as: 1) a Mississippi county that has a population less than 50,000 individuals; 2) an area that is less than 500 individuals per square mile; or 3) a municipality of less than 15,000 individuals.

SOURCE: Miss. Code Ann. § 41-3-15

Subchapter 4. HEALTH SYSTEMS IN MISSISSIPPI

Rule 1.4.1 Mississippi is committed to assisting communities in determining the best course of action in planning and developing rural health systems, including plans that improve access to health services, reduce duplication of services, and develop and support rural health networks. The Mississippi Public Health System is led by the MSDH, an agency which includes an 11-member Board of Health, State Health Officer, central administrative offices in Jackson, nine district offices, and 81 county health departments. The MSDH promotes and protects the health of the citizens of Mississippi through health promotion, disease prevention, and the control of communicable diseases. This section describes some of the types of public rural health facilities and systems in Mississippi that comprise the rural health infrastructure.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.4.2 Hospitals- Mississippi has 111 hospitals; 95 acute care, 4 psychiatric, 1 rehabilitation, 1 OB/GYN, and 10 long-term acute care. There are five federal hospitals in the state. Ninety-five hospitals are classified as medical/surgical based on the type of service that the hospitals provided to the majority of admissions.
Seven counties in the state do not have a hospital: Amite, Benton, Carroll, Humphreys, Issaquena, Itawamba, and Tunica. The federal government operates two Veterans' Administration Hospitals, one in Jackson and one in Biloxi. The United States Air Force operates medical facilities at Columbus and Biloxi to serve active duty and retired military personnel and their dependents. The Indian Health Service funds the operation of the Choctaw Health Center, an 18-bed acute care hospital in Philadelphia which is operated by and provides health care services to the Mississippi Band of Choctaw Indians. Forty-one hospitals reported having rural health clinics and 933,280 rural health clinic visits.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.4.3 Mississippi has 32 critical access hospitals and 51 rural hospitals eligible for the Small Rural Hospital Performance Improvement Grant Program.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.4.4 Local Health Departments- The MSDH operates at least one county health department in every county except Issaquena which is covered by the health department in Sharkey county. These 81 county health departments have more than 100 clinic sites throughout the state. Department staff includes public health nurses, nurse practitioners, physicians, disease investigators, environmentalists, medical records clerks, social workers, and nutritionists. The county health departments provide immunizations, family planning, WIC (Special Supplemental Food Program for Women, Infants, and Children), tuberculosis treatment and prevention services, sexually-transmitted disease (including HIV/AIDS) services, and other communicable disease follow-up. Additional services, such as child health and maternity services are available based on the county's need. The number and type of staff may vary according to the need and resources in each particular county; however, every county provides all general public health services.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.4.5 Rural Health Clinics- Rural Health Clinics (RHCs) provide care in areas designated by the U.S. Department of Health and Human Services as medically underserved. These clinics use physician’s assistants and nurse practitioners under the general direction of a physician, who is located within 15 miles of the clinic, to provide outpatient primary care services to patients in rural areas. RHCs may be freestanding facilities owned by physicians or provider-based clinics established by hospitals, nursing homes, or home health agencies. The July 2014 MSDH Facilities Directory reported that Mississippi had 159 certified RHCs and the state fiscal year 2013 Report on Hospitals indicated that there were 933,280 visits for the 99 hospitals with rural health clinics.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.4.6 Community Health Centers (CHCs)- The availability and accessibility of primary health care services is essential to meet the needs of the state’s population. Community Health Centers (CHCs) provide access to medical care for residents who are plagued by a shortage of medical services, financial restrictions, and other social or economic barriers. CHCs are federally-subsidized, non-profit corporations that must serve populations identified by the U.S. Department of Health and Human Services as medically underserved. This status indicates that the geographic area has limited medical resources; other factors include poverty and lack of health insurance. CHCs offer a range of services, including medical, dental, radiology, pharmacy, nutrition, health education, and transportation. Mississippi has 21 CHCs, with 207 sites, including school clinic locations.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.4.7 Long-Term Care- Mississippi's long-term care (nursing home and home health) patients are primarily disabled elderly people, who make up 20 percent of the 2025 projected population above age 65. Projections place the number of people in this age group at approximately 642,506 by 2025, with more than 186,327 disabled in at least one essential activity of daily living.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.4.8 The risk of becoming frail, disabled, and dependent rises dramatically with age. While the average length of life has increased, people are often living longer with some very disabling chronic conditions which the present medical system can "manage" but not cure. So while the lives of many people have been prolonged through advances in medicine and public health, the quality of an older person's life often suffers. Aged individuals may become dependent on medical technology and professional care providers for years - not just weeks or months.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.4.9 There were 210 nursing home sites and 61 home health agencies listed in the MSDH's July 2014 Facilities Directory.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.4.10 Emergency Medical Services (EMS)- As a primary source of pre-hospital care, Emergency Medical Services (EMS) are an important part of health/medical care in rural communities. Quick access to health care in rural communities can be problematic, particularly given the higher levels of motor vehicle crash deaths, injuries, and fires. The Federal Government, through the Emergency Medical Services Act of 1973, established standards for the organization of emergency services. The Mississippi EMS Act of 1974, and subsequent amendments, authorized the MSDH to create a Bureau of Emergency Medical Services (BEMS). The Act authorized this Bureau to license all ambulance services in Mississippi, to require specific equipment and standards for emergency vehicles, to provide training and certification of emergency medical technicians (EMTs) and Medical First Responders, and to assist with the creation and the provision of technical assistance.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.4.11 The training of emergency medical personnel includes ambulance operators and emergency medical technicians (EMTs) of both advanced and basic levels. Mississippi requires all ambulance drivers to have EMS driver certification (EMS-D). To qualify, an individual must complete an approved driver training program that involves driving tasks, vehicle dynamics, vehicle preventative maintenance, driver perception, night driving, and information on different driving maneuvers. This training offers both academic and clinical (practical hands on) experiences for the prospective ambulance driver. Additionally, all emergency medical technicians – both advanced level and basic level – must complete a National Highway Safety and Traffic Administration training program

for the respective level. This training provides extensive academic and clinical hours for the prospective students. Upon completion, students must pass the National Registry for Emergency Medical Technicians test and receive their national certification before applying for the Mississippi certification.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.4.12 With the passage of legislation during the 1991 Mississippi Legislative Session, the MSDH was designated as the lead agency to develop a trauma care plan for the state. The primary goal of the Mississippi Trauma System Care Program is to provide the architecture for a trauma system which will decrease morbidity and mortality from traumatic injury.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.4.13 Trauma Centers in the Mississippi Trauma System care for a variety of injured patients. These patients are provided immediate resuscitation and stabilization, and definitive acute care. The centers strive to give excellent trauma care to these patients. The Trauma Centers along with the Trauma Regions are dedicated to trauma care, teaching and injury prevention in an effort to decrease death and disabilities. There are rules and regulations mandated by the Mississippi State Department of Health, Bureau of Emergency Medical Services with which compliance is necessary to be a designated Trauma Center. These rules and regulations are examined at a frequent basis as to their compliance.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.4.14 Trauma patients are cared for at these Trauma Centers regardless of that patient's financial status. The multi-disciplinary approach follows the patient throughout the continuum of care from pre-hospital to rehabilitation. As of August 1, 2013, there were 83 hospitals participating in the Mississippi Trauma Care System: four Level I Trauma Centers, four Level II Trauma Centers, 15 Level III Trauma Centers, 60 Level IV Trauma Centers and one Burn Center. Fifty-eight ground and 17 air EMS providers service the 82 counties in Mississippi.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.4.15 Mental Health- The Mississippi Department of Mental Health (MDMH) administers programs for Mississippians with mental illness, substance abuse problems and intellectual/developmental disabilities. The agency provides a network of services through three major components: state-operated programs; regional community mental health/mental retardation centers; and nonprofit service agencies/organizations. The state-operated programs include four state comprehensive behavioral health programs, five IDD regional programs, a mental health community living program, and two specialized programs for adolescents. These programs serve designated counties or service areas in the State and provide inpatient psychiatric, chemical dependence, forensic, limited medical/surgical hospital services, community mental health services, intermediate care program

services for persons with intellectual and developmental disabilities, and a range of community services for persons with developmental disabilities. Nursing facility services are provided on the grounds of two of the state's comprehensive psychiatric facilities. There are 15 regional centers with governing authorities that are considered regional and not state-level entities. The Department of Mental Health certifies, monitors, and assists the centers and provides contracts to provide community-based mental health and substance abuse services. Programs provided through the nonprofit agencies include community-based alcohol/drug abuse services, community services for persons with developmental disabilities and community services for children with mental illness or emotional problems.

SOURCE: Miss. Code Ann. § 41-3-15

Subchapter 5. HEALTH WORKFORCE

Rule 1.5.1 Essential health service delivery requires an adequate supply and appropriate distribution of fully qualified physicians, nurses, and other health care personnel. High quality health care services depend on the availability of competent health care personnel in sufficient numbers to meet the population's needs. Although the state has improved its population-to-physician ratio in recent years, not all physicians are available to the general population. Only 41% of physicians are primary care providers the remaining are specialist or other and tend to treat patients only by referral. Some physicians occupy administrative or teaching positions and treat patients only part-time, if at all.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.5.2 According to the United States Department of Health and Human Services' website on December 31, 2014, Mississippi had 140 primary care HPSAs, 125 dental HPSAS, and 13 mental health catchment areas designated as HPSAs. Seventy-four of the primary care HPSA designations were single county designations and seventy-seven of the dental HPSA designations were single county designations.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.5.3 Physicians- The MSDH State Health Plan is reporting that Mississippi had 5,499 active medical doctors, 350 osteopaths, and 67 podiatrists licensed by the Board of Medical Licensure for FY 2012 (licensing year 2013) for a total of 5,916 active licensed physicians practicing in the state. This number represents an increase of 99 physicians, or more than 1.02 percent, from FY 2011 (licensing year 2013). Approximately 2,267 (41 percent) of the state's active medical doctors are primary care physicians. The primary care physicians included 765 family practitioners, 88 general practitioners, 681 internal medicine physicians, 327 obstetrical and gynecological physicians, and 406 pediatricians.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.5.4 Dentists- The Mississippi State Board of Dental Examiners reported 1,051

licensed (1,025 “active” and 26 “inactive”) dentists in the state as of June 2013, with 54 new dentists licensed during calendar year 2012.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.5.5 Nursing- The Mississippi Board of Nursing reported 43,103 registered nurses (RNs) licensed in FY 2012 with 86 percent (35,266) who worked full or part-time in nursing careers. That included 20,433 (59 percent) in hospitals; 3,598 (10 percent) in community, public, or home health; 2,499 (7 percent) in physicians’ offices; 1,896 (5 percent) in nursing homes; and the remainder in other nursing careers. RNs by degree in FY 2012 included, 1,378 diploma, 18,102 associates, 1,300 baccalaureate non-nursing, 9,961 baccalaureate nursing, 684 masters non- nursing, 3,549 masters nursing, and 293 doctorate degrees.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.5.6 Emergency Medical Services (EMS)- Emergency Medical Services (EMS) are health care services delivered under emergency conditions that occur as a result of a patient’s condition, natural disasters, or other situations. EMS are provided by public, private, or non-profit entities with the authority and the resources to effectively administer services.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.5.7 Many people with greatly diverse backgrounds and talents contribute to the EMS System in Mississippi. These include: bystanders, firefighters, law enforcement officers, emergency medical dispatchers, medical first responders, emergency medical technicians, nurses, physicians, and volunteers. The Legislature authorized the MSDH Bureau of Emergency Medical Services (BEMS) to certify Mississippi’s medical first responders beginning July 1, 2004. There are five levels of certified EMS providers. They are as follows:

a. Medical First Responder
b. Emergency Medical Services – Driver
c. Emergency Medical Technician – Basic (EMT-Basic)
d. Emergency Medical Technician – Intermediate (EMT Intermediate)
e. Emergency Medical Technician – Paramedic (EMT-Paramedics)

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.5.8 For FY 2012, the MSDH Bureau of Emergency Medical Services reported a total of 1,906 EMT Basics certified in the state; 1,599 EMT Paramedics; and 24 EMT intermediates.

SOURCE: Miss. Code Ann. § 41-3-15

Subchapter 6. MISSISSIPPI RURAL HOSPITAL FLEXIBILITY PROGRAM AND CRITICAL ACCESS HOSPITALS

Rule 1.6.1 Mississippi Rural Hospital Flexibility Program- The Medicare Rural Hospital Flexibility Program (FLEX) is a federal initiative that provides funding to state governments to strengthen rural health. The purpose of the FLEX Program is to help sustain the rural healthcare infrastructure, with critical access hospitals (CAHs) as the hub of an organized system of care, through mechanisms of the program. These mechanisms include the FLEX State Rural Health Plan (SRHP), CAHs, Networks, Quality Improvement, and EMS initiatives. The Mississippi Office of Rural Health at the MSDH administers the Medicare Rural Hospital Flexibility Program for the state of Mississippi. The FLEX Program includes designating hospitals as CAHs in the state and providing assistance to the facilities.

Rule 1.6.2 The 1998 session of the Mississippi Legislature authorized the MSDH to develop regulations for the designation of CAHs in the state.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.6.3 Critical Access Hospitals- CAHs are acute care facilities that provide outpatient, emergency, and limited inpatient services and are for cost based Medicare reimbursement. Currently, Mississippi has 32 hospitals designated as CAHs. Additional requirements for CAHs include being located in a rural area, operating a maximum of 25 acute care beds, having an average inpatient stay of 96 hours, having a referral network agreement, and providing emergency care 24 hours a day. CAHs can also participate in swing bed programs.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.6.4 Mississippi's Critical Access Hospital Information- Table 2 provides utilization and other information for Mississippi CAHs obtained from the calendar year 2013 MSDH Annual Survey of Hospital reports.

TABLE 2	
County Owned	65%
Corporate Ownership (not-for-profit)	24%
City and County Owned	3%
For Profit	8%
Part of Health System	28%
Full-Time Employees	3,286
Part-Time Employees	1,080
Workers on Contract	162
RNs	825
LPNs	345
Ancillary Personnel	420
ER Visits	152,016
Non-RHC Clinic Visits	138,644

Average Daily Census	160.32
Admissions	12,732
Inpatient Days	59,359
Swing-bed Days	51,938
RHC Visits	245,705

SOURCE: Miss. Code Ann. § 41-3-15

Subchapter 7. CRITICAL ACCESS HOSPITAL DESIGNATION

Rule 1.7.1 The designation process for achieving CAHs status involves two steps: 1) submission of a satisfactory CAH Application (application discussed in part F of this section) to the CAH Certification Application Review Committee; and 2) successful completion of a CAH survey by the Division of Licensure and Certification of the MSDH. The CAH Certification Application Review Committee is discussed in part G of this section.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.7.2 To satisfy state requirements for designation as a CAH, a hospital must meet all federal requirements for designation including successful completion of the survey by the Division of Licensure and Certification.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.7.3 Federal requirements for CAHs are listed below:

1. Located in a state that has established a Medicare Rural Hospital Flexibility Program with the Centers for Medicare and Medicaid Services (CMS).

2. Currently participating in Medicare as a rural public, non-profit or for-profit hospital; or was a participating hospital that ceased operation during the 10-year period from November 29, 1989, to November 29, 1999; or is a health clinic or health center that was downsized from a hospital.

3. Located in a rural area or area treated as rural.

4. Located more than a 35-mile drive from any other hospital or CAH (in mountainous terrain or in areas with only secondary roads available, the mileage criterion is 15 miles).

5. Maintains no more than 25 inpatient beds.

6. Maintains an annual average length of stay of 96 hours per patient for acute inpatient care.

7. Complies with all CAH Conditions of Participation, including the requirement to make available 24-hour emergency care services seven days per week.

8. Staff must be sufficient to provide the services essential to the operation of the CAH (e.g., emergency services, direct services, and nursing services).

9. The CAH must have a professional health care staff that includes one or more doctors of medicine or osteopathy, and may include one or more physician assistants, nurse practitioners, or clinical nurse specialists.

10. A registered nurse, clinical nurse specialist, or licensed practical nurse is on duty whenever the CAH has one or more inpatients.

11. Inpatient and emergency care, laboratory and x-ray services are required. Some ancillary services (lab, radiology) may be provided part-time off-site.

12. Emergency services are required 24 hours a day, seven days a week. Staff in the emergency room must have emergency services training/experience.

13. A system must be in place with the local emergency medical system so that emergency medical personnel are aware of who is on call and how to contact them.

14. A doctor of medicine or osteopathy must be available by phone or radio 24 hours a day, seven days a week.

15. Facilities must have an agreement with at least one hospital that is a member of the network for:

    a. Patient referral and transfer

    b. The development and use of communications systems

    c. The provision of emergency and non-emergency transportation

    d. Credentialing and quality assurance

16. CAH applicants must meet all additional CAH Conditions of Participation as established by CMS. Compliance with the CMS CAH Conditions of Participation is determined by the survey conducted by the Division of Licensure and Certification of the MSDH.

SOURCE: Miss. Code Ann. § 41-3-15

Subchapter 8: STATE CRITERIA FOR NECESSARY PROVIDER PROVISION

Rule 1.8.1 A hospital that does not meet the federal mileage requirements to be certified as a CAH and is otherwise eligible for designation will be certified by the state as a necessary provider of health care services if it meets two (2) or more of the following criteria:

1. Criteria 1: The hospital is located in a county that is federally designated as a HPSA for medical care.

2. Criteria 2: The hospital is located in a county that is federally designated as a Medically Underserved Area (MUA).

3. Criteria 3: The hospital is located in a county where the percentage of families with incomes less than 100% of the federal poverty level is higher than the state average for families with incomes less than 100% of poverty.

4. Criteria 4: The hospital is in a county with an unemployment rate that exceeds the state's average unemployment rate.

5. Criteria 5: The hospital is located in a county with a percentage of population age 65 and older that exceeds the state's average.

6. Criteria 6: The number of Medicare admissions to the hospital exceeds 50% of the facility's total number of admissions as reported in the most recent Hospital Annual Report for the facility.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.8.2 Any hospital not meeting two (2) of the above criteria may appeal the decision to the MSDH, Office of Health Policy and Planning. Appeals must be submitted in writing and will only be considered if the appeal provides sound evidence that future access to health care for the citizens in the facility's primary service area, as defined by the most recent patient origin study, will be jeopardized if it is not declared a necessary provider of health care services.

SOURCE: Miss. Code Ann. § 41-3-15

Rule 1.8.3 Facilities that meet the Necessary Provider Provision criteria are still required to complete the designation application process which includes: 1) submission of a satisfactory CAH Application to the Critical Access Hospital Certification Application Review Committee; and 2) successful completion of a CAH survey by the Division of Licensure and Certification of the MSDH.

SOURCE: Miss. Code Ann. § 41-3-15

Subchapter 9. CRITICAL ACCESS HOSPITAL DESIGNATION APPLICATION

Rule 1.9.1 The CAH Designation Application will include the following information:

1. A community needs assessment which includes an inventory of local health services and providers.

2. Evidence of information activities to inform county and community residents, public officials, and health care providers of the proposed conversion of the hospital to CAH designation.

3. A financial feasibility study which will include:

   a. Audited financial statements and notes for the three most recently completed years;

   b. Adult and pediatric admissions, adult and pediatric patient days, deliveries, and inpatient surgeries;

   c. Outpatient and emergency room utilization data;

   d. An inventory of medical staff by name, age, and medical specialty;

   e. A three year CAH cost and revenue projection;

   f. A signed network agreement with a full service hospital detailing the facility relationships including:
      i. patient referral and transfer;
      ii. communications systems;
      iii. provision of emergency and non-emergency transportation;
      iv. arrangements for credentialing and quality assurance; and
      v. other information and data which the Review Committee may determine is needed in order to make an appropriate recommendation.

SOURCE: Miss. Code Ann. § 41-3-15

Subchapter 10. CRITICAL ACCESS HOSPITAL CERTIFICATION APPLICATION REVIEW COMMITTEE

Rule 1.10.1 A CAH Certification Application Review Committee will be established by the MSDH to review CAH applications and make recommendations to the State Health Officer regarding designation. The committee membership will be comprised of one representative from the Mississippi Office of Rural Health (MORH) located within the MSDH, one representative from the MSDH Division of Licensure and Certification, one representative from the Mississippi Hospital Association, and two hospital representatives appointed by the Mississippi Hospital Association. The State Health Officer may appoint representatives of additional groups to the committee.

SOURCE: Miss. Code Ann. § 41-3-15

Subchapter 11. CRITICAL ACCESS HOSPITAL RELOCATION REQUIREMENTS

Rule 1.11.1 Information regarding the guidelines for 42 CFR 485.610(c), concerning CAH location relative to other hospitals or CAHs, and 42 CFR 485.610(d), concerning relocation of CAHs with a necessary provider designation, is available at the CMS Web site. This site will also provide information about eligibility for the shorter, 15-mile standard due to mountainous terrain or lack of primary roads.

SOURCE: Miss. Code Ann. § 41-3-15

Subchapter 12. LIST OF MISSISSIPPI CRITICAL ACCESS HOSPITALS

Rule 1.12.1 A current list of Mississippi CAHs is available on the MSDH website.

SOURCE: Miss. Code Ann. § 41-3-15

Title 15: Mississippi State Department of Health

Part 9: Office of Health Policy and Planning

Subpart 100: COVID-19 Mississippi Local Provider Innovation Grant Program

Chapter 1. COVID-19 Mississippi Local Provider Innovation Grant Program

Subchapter 1. Authority and Purpose

Rule 1.1.1. Senate Bill 2820 adopted by the Mississippi State Legislature in its regular 2022 session authorizes the State Department of Health to adopt rules and regulations to establish the COVID-19 Mississippi Local Provider Innovation (CMLPI) Grant Program.

The CMLPI Grant Program is to be administered by the State Department of Health to grant funding to local health care providers for the purpose of strengthening and improving the health care system and increasing access to health care services to help communities achieve and maintain optimal health by providing transitional assistance to providers.

Rule 1.1.2. Pursuant to Mississippi Code § 41-99-5(8), the MSDH may use a portion of any grant monies appropriated for the CMLPI Grant Program for administration of the program and to pay reasonable expenses incurred by MSDH. The department may expend up to one and one-half (1-1/2%) of the amount appropriated for the program for the expenses of administrating the program, or the specific amount authorized for administrative expenses in the appropriation bill if that amount is higher.

SOURCE: Senate Bill 2820, 2022 Regular Legislative Session & HB 518 2023 Regular Session

Subchapter 2. Definitions

Rule 1.2.1. The following terms shall have the following meanings:

1. **"Department"** means the Mississippi State Department of Health and staff, and their designated representatives.

2. **"Local Health Care Provider or Provider"** means a facility that is licensed, certified or otherwise authorized or permitted by law to provide health care in the ordinary course of business in the State of Mississippi, including, but not limited to, skilled nursing facilities, direct primary care clinics, provider owned clinics, rural health clinics, academic medical centers, community health centers and/or independent physician practices.

3. **"Transitional assistance"** means any assistance related to changing a Provider's current health care delivery model to a model more appropriate for the community that the Provider serves, including, but not limited to:

    A. Conducting a market study of health care services needed and

provided in the community;

B. Acquiring and implementing new technological tools and infrastructure, including, but not limited to, telemedicine delivery methods, development of health information exchanges platforms to electronically share medical records, electronic health record optimization, purchasing connected devices, upgrading digital devices, improving broadband connectivity, public health reporting, and implementing online or mobile patient appointment management applications; and

C. Supporting the implementation of population health management.

May include reimbursement of expenses of transitional assistance meeting federal and state requirements that were incurred by providers during the period beginning on March 3, 2021, through December 31, 2024.

SOURCE: Senate Bill 2820, 2022 Regular Legislative Session & HB 518 2023 Regular Session

Chapter 2. Grant Program Eligibility and Award

Subchapter 1. Local Health Care Provider (Provider) Eligibility

Rule 2.1.1. To be eligible, Providers must include the following information in their grant application:

1. A description of the location(s) for which the grant monies will be expended, including the name and location(s) of where the Provider administers health care services;

2. A statement of the amount of grant monies requested;

3. A description of the needs of the Provider, the transitional assistance for which the grant monies will be expended and how such transitional assistance will meet the stated needs;

4. Evidence that the Provider has played an active role in the community to combat the spread of COVID-19, including, but not limited to, testing, vaccination, and antibody treatment; and

5. Any other information the Department may request from the Provider or requires as part of the Department's application process to administer the CMPLI Grant Program.

SOURCE: Senate Bill 2820, 2022 Regular Legislative Session

Rule 2.1.2. Grant applicants are limited to one (1) application per business entity as determined by the applicant's attestation and their business filing status with the Secretary of State. Subsidiaries of the entity are not eligible to submit separate applications. Health systems that affiliate, own or control multiple clinics are only eligible to

submit one (1) application under the parent entity.

SOURCE: Senate Bill 2820, 2022 Regular Legislative Session

Subchapter 2. Award Amount

Rule 2.2.1. Subject to fund availability, the Department shall determine the amount awarded to each applicant based on the applicant's grant application. The maximum amount awarded per applicant shall not exceed $250,000.

SOURCE: Senate Bill 2820, 2022 Regular Legislative Session

Chapter 3. CMLPI Program – Round One Applicants

Subchapter 1. Applications

Rule 3.1.1 Applications for the CMLPI Grant Program must be submitted in the manner prescribed by the Department. Applicants should thoroughly read the Application guidelines and follow all instructions. The Department may be contacted for assistance. Requests for participation in round one of the CMLPI Program are made through a CMLPI Grant Application and all:

1. Eligible Recipients will be required to execute a sub-grant agreement with the Department and certify that the grant awarded under this program is for allowable expenditures under the American Rescue Plan Act (ARPA) of 2021, Public Law 117-2, which amends Title VI of the Social Security Act; and its implementing guidelines, guidance, rules, regulations and/or other criteria, as may be amended or supplemented from time to time, by the United States Department of the Treasury.

2. First Round CMLPI Program Grant Applications must be received by the Department electronically on or before 5:00 p.m., on August 31, 2022, for first round consideration. The Department has the option to return late applications or accept late applications with or without penalty to the late applicant.

3. Acceptance of a Provider's application does not obligate the Department to award a grant to the applicant.

4. The maximum amount of all grants that may be received by an applicant is Two Hundred Fifty Thousand Dollars ($250,000).

5. If request for grant application funding during the first round or subsequent rounds exceed the amount appropriated or the funds remaining, then the Department may allocate awards based on criteria established by the Department.

SOURCE: Senate Bill 2820, 2022 Regular Legislative Session & HB 518 2023 Regular Session

Rule 3.1.2. The Department may contact applicants for clarification of information presented in the application. The application review and award process shall include the following:

A. The application will be reviewed by Department staff to determine if it meets the minimum requirements for consideration.

B. Applicants will be notified in writing of the funding decision.

SOURCE: Senate Bill 2820, 2022 Regular Legislative Session

Rule 3.1.3. As funds are available, subsequent rounds for applicants may be announced by the Department and applicants shall meet the same requirements listed in this Chapter.

SOURCE: Senate Bill 2820, 2022 Regular Legislative Session

Subchapter 2. Award Allocation for Grantees

Rule 3.2.1. The CMLPI Grant Program Award Allocation will be distributed among grantees based on evaluation criteria, activities undertaken, and performance measures.

The award per grantee shall not exceed $250,000. To ensure that all awarded funds will be utilized for legislatively intended purposes, Providers must submit an acceptable CMLPI Grant Program Application. All awards are subject to funding availability.

SOURCE: Senate Bill 2820, 2022 Regular Legislative Session

Title 15: Mississippi State Department of Health

Part 9: Office of Health Policy and Planning

Subpart 101: Mississippi Rural Hospital Loan Program

Chapter 1. Mississippi Rural Hospital Loan Program

Subchapter 1. Authority and Purpose

Rule 1.1.1. House Bill 365, adopted by the Mississippi State Legislature in its regular 2022 session, authorizes the State Department of Health to adopt rules and regulations to establish the Mississippi Rural Hospital Loan Program (RHLP).

Rule 1.1.2. The Mississippi RHLP is established in the State Department of Health to provide loans to rural hospitals to assist the hospitals in providing needed direct health care services for Mississippi citizens. A rural hospital may apply for and use the loan for the following purposes:

1. Maintaining or upgrading the rural hospital's facilities.

2. Maintaining or increasing the current staff of the rural hospital; or

3. Providing health care services that are not currently available to citizens.

SOURCE: House Bill 365, 2022 Regular Legislative Session

Subchapter 2. Definitions

Rule 1.2.1. The following terms shall have the following meanings:

1. **"Department"** means the Mississippi State Department of Health and staff, and their designated representatives.

2. **"Rural Hospital"** means a licensed Mississippi hospital that has fifty (50) or fewer licensed general acute, non-specialty beds.

SOURCE: House Bill 365, 2022 Regular Legislative Session

Chapter 2. Rural Hospital Operations and Facilities Revolving Loan Fund

Subchapter 1. Revolving Loan Fund

Rule 2.1.1. The fund shall consist of legislative appropriations, federal funds, contributions, donations, gifts, and monies from any other source that are made available for deposit into the fund.

SOURCE: House Bill 365, 2022 Regular Legislative Session

Rule 2.1.2. Monies in the fund shall be expended by the Department upon appropriation of the Legislature for the sole purpose of providing loans to Rural Hospitals under

the provisions of this Subpart.

SOURCE: House Bill 365, 2022 Regular Legislative Session

Rule 2.1.3. Monies remaining in the fund at the end of a fiscal year shall not lapse into the State General Fund, and any interest earned from the investment of monies in the fund shall be deposited to the credit of the fund.

SOURCE: House Bill 365, 2022 Regular Legislative Session

Rule 2.1.4. Loan repayments, including interest, will be deposited back in the revolving loan fund for administration of the Mississippi RHLP and for issuance of future loans to other Rural Hospitals.

SOURCE: House Bill 365, 2022 Regular Legislative Session

Chapter 3. Mississippi Rural Hospital Loan Program Advisory Committee

Subchapter 1. Advisory Committee Purpose

Rule 3.1.1. The Department shall establish an Advisory Committee to review the Mississippi RHLP applications.

SOURCE: House Bill 365, 2022 Regular Legislative Session

Rule 3.1.2. The Committee shall meet to vote on their recommendation for each application.

SOURCE: House Bill 365, 2022 Regular Legislative Session

Subchapter 2. Advisory Committee Membership

Rule 3.2.1. To ensure that the Committee has broad representation and a sufficient number of members to review applications, Rural Hospitals are limited to having one (1) representative serve on the Committee at a time. The Committee shall be made up of the following entities/persons:

1. A banker with experience lending to rural hospitals/entities.
2. One (1) representative from the Mississippi Hospital Association
3. Mississippi State Department of Health, Chief Financial Officer
4. One (1) representative from the Mississippi State Department of Health, Division of Health Facilities Licensure and Certification
5. One (1) representative from the Mississippi State Department of Health, Division of Health Planning and Resource Development
6. One attorney from the Mississippi State Department of Health, Office of General Counsel
7. Mississippi State Department of Health, Senior Deputy
8. One Rural Hospital Chief Executive Officer (limited to a two (2) year term)
9. One Rural Hospital Chief Financial Officer (limited to a two (2) year term)

SOURCE: House Bill 365, 2022 Regular Legislative Session

Rule 3.2.3. The Mississippi Hospital Association shall provide recommendations for the Rural Hospital Chief Executive Officer and Chief Financial Officer representatives.

SOURCE: House Bill 365, 2022 Regular Legislative Session

Rule 3.2.2. The Committee shall have the following officers:

1. Chairperson who shall chair the Committee meeting.

2. Vice-Chairperson who shall exercise the duties of the Chairperson in his/her absence.

SOURCE: House Bill 365, 2022 Regular Legislative Session

Subchapter 3. Advisory Committee Business

Rule 3.3.1. In order for the Committee to conduct official business a quorum of five (5) members must be present.

SOURCE: House Bill 365, 2022 Regular Legislative Session

Rule 3.3.2. A member present may vote for or against any motion, or the member may abstain. Voting by proxy is not permitted.

SOURCE: House Bill 365, 2022 Regular Legislative Session

Rule 3.3.3. Advisory Committee Members shall not review applications for hospitals or hospital systems in which they are employed.

SOURCE: House Bill 365, 2022 Regular Legislative Session

Rule 3.3.4. The minutes of the Committee meeting shall reflect the vote on each application.

SOURCE: House Bill 365, 2022 Regular Legislative Session

Rule 3.3.5. The minutes of all Committee meetings shall be the responsibility of the Department and shall become official upon approval of the Committee.

SOURCE: House Bill 365, 2022 Regular Legislative Session

Chapter 4. Mississippi Rural Hospital Loan Terms and Process

Subchapter 1. Loan Terms and Conditions

Rule 4.1.1. The Department shall determine the terms and conditions of each loan, including the repayment of the loan.

SOURCE: House Bill 365, 2022 Regular Legislative Session

Rule 4.1.2. Issuance of a loan is subject to the following provisions and terms:

1. To be eligible for a loan, a Rural Hospital must submit to the Department a current financial audit showing that the hospital is in good financial condition.

2. To qualify for a loan, a Rural Hospital must request and use the funds for one or more of the following purposes:

   A. To maintain or upgrade the existing Rural Hospital's facilities;

   B. To maintain or increase the current staff of the Rural Hospital; or

   C. To provide health care services that are not currently available in the community which the Rural Hospital serves.

3. The amount of the loan shall be not less than $25,000.00 and not more than $100,000.00 per Rural Hospital.

4. Security or collateral for a loan shall be required from the Rural Hospital.

5. The term of the loan shall not exceed twenty (20) years, subject to the life of the collateral for the loan.

6. The rate of interest on a loan shall be fixed and equal to one percent (1%) per annum.

   A. Interest will begin accruing no later than the following:

      i. Final disbursement of loan funds, or

      ii. One (1) year from Committee approval.

7. Principal and interest payments will be required monthly starting no later than the following:

   A. Final disbursement of loan funds, or

   B. One (1) year from Committee approval.

8. The loan may not be used to pay costs incurred before approval of the loan by the Committee, and the loan may not be refinanced.

9. One hundred percent (100%) of the project costs must be incurred by the Rural Hospital within one (1) year of approval of the loan by the Committee.

10. The Rural Hospital receiving a loan must employ at least eighty-five percent (85%) of the number of full-time employees employed on the date of approval of the loan throughout the term of the loan agreement. For the purpose of this rule, a "full-time employee" means a person employed by the Rural Hospital for a minimum of thirty-five (35) hours per week (this does not include temporary workers, temp-to-hire workers, part-time workers or traveling medical professionals).

SOURCE: House Bill 365, 2022 Regular Legislative Session

Subchapter 2. Loan Process

Rule 4.2.1. The Department may extend a loan to a Rural Hospital provided the underwriting and financial analysis is satisfactory to the Department. The Rural Hospital may be subject to other underwriting and financial measurements and annual monitoring as deemed acceptable by the Department.

SOURCE: House Bill 365, 2022 Regular Legislative Session

Rule 4.2.2. An applicant must first submit to the Department a current financial audit showing that the hospital is in good financial condition, a Letter of Good Standing from the Secretary of State, and an official Letter of Intent stating the applicant's intention to apply for a loan. The letter must at a minimum include the following:

1. A detailed description of the project and purpose for applying for the loan to determine program eligibility;

2. The proposed financing structure and collateral requirements; and

3. Any other terms of the applicant's proposed project.

SOURCE: House Bill 365, 2022 Regular Legislative Session

Rule 4.2.3. If the project is eligible, Department staff will provide an application for the applicant to complete. Applicants should thoroughly read the application and follow all instructions. Applications must be submitted in the manner specified by the Department.

SOURCE: House Bill 365, 2022 Regular Legislative Session

Rule 4.2.4. An original and one copy of the completed Mississippi RHLP Application must be submitted to the Department. A one-thousand-dollar ($1,000.00) application fee must also be submitted by the Rural Hospital at the time of submission of the completed application.

SOURCE: House Bill 365, 2022 Regular Legislative Session

Rule 4.2.5. Department staff will review applications for eligibility, completeness and accuracy and will verify the underwriting calculations.

SOURCE: House Bill 365, 2022 Regular Legislative Session

Rule 4.2.6. Upon completion of the Department's review and subject to fund availability, a draft Mississippi RHLP Advisory Committee Report indicating the amount of the loan, terms, and conditions to be extended and any other requirements will be sent to the applicant for review and acceptance.

SOURCE: House Bill 365, 2022 Regular Legislative Session

Rule 4.2.7. Once the draft Committee Report is accepted, the loan documents will be prepared.

1. The loan documents will be provided to the applicant for review.

2. The borrower will pay all closing fees, legal fees, including expenses of counsel to the Department, necessary for the preparation of the loan documents.

SOURCE: House Bill 365, 2022 Regular Legislative Session

Rule 4.2.8. Upon receipt of the executed loan documents from the applicant, the project will be presented to the Mississippi RHLP Advisory Committee.

SOURCE: House Bill 365, 2022 Regular Legislative Session

Rule 4.2.9. After Committee approval, the State Health Officer or their designee will sign the loan documents and copies of the agreement and documents will be provided to the applicant.

1. A commitment/closing fee of one percent (1%) with a minimum of $1,000.00 is due prior to Committee approval.

2. Eligible spending may begin after approval of the loan by the Committee.

SOURCE: House Bill 365, 2022 Regular Legislative Session

Rule 4.2.10. Upon completion of the loan documents, requests for disbursement of the loan funds may be submitted no more than once per month. Each request will be reviewed for required supporting documentation, including invoices and proof of payment.

SOURCE: House Bill 365, 2022 Regular Legislative Session

Rule 4.2.11. The Rural Hospital will be required to provide financials and status reports annually and any other frequency requested by the Department to monitor the loan and projects for compliance.

SOURCE: House Bill 365, 2022 Regular Legislative Session