By: Senator(s) Bean, Burton, Gollott, Woodfield, Gordon, Thames, Carlton, Little, Browning, Walls, White (29th), Canon, Harden, Stogner, Dickerson, Minor, Carter, Robertson, Smith, Harvey, Ferris, Hall, Farris, Hawks, Hamilton, Dearing, Cuevas, Scoper, Mettetal, Turner, Ross, Moffatt, Furniss, Jackson, Horhn, Johnson (19th)

To: Public Health and Welfare; Appropriations

SENATE BILL NO. 2679
(As Sent to Governor)

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 TO DIRECT THE DIVISION OF MEDICAID TO DEVELOP AND IMPLEMENT A
3 REFERRAL PROCESS FOR LONG-TERM CARE ALTERNATIVES FOR MEDICAID
4 BENEFICIARIES AND APPLICANTS; TO PROVIDE THAT NO MEDICAID
5 BENEFICIARY SHALL BE ADMITTED TO A MEDICAID-CERTIFIED NURSING
6 FACILITY UNLESS A LICENSED PHYSICIAN CERTIFIES ON A STANDARDIZED
7 FORM THAT NURSING FACILITY CARE IS APPROPRIATE FOR THAT PERSON; TO
8 PROVIDE THAT THE PHYSICIAN MUST FORWARD A COPY OF HIS
9 CERTIFICATION TO THE DIVISION OF MEDICAID WITHIN 24 HOURS; TO
10 REQUIRE THE DIVISION TO DETERMINE, THROUGH AN ASSESSMENT OF THE
11 APPLICANT CONDUCTED WITHIN TWO BUSINESS DAYS AFTER RECEIPT OF THE
12 PHYSICIAN'S CERTIFICATION, WHETHER THE APPLICANT ALSO COULD LIVE
13 APPROPRIATELY AND COST-EFFECTIVELY AT HOME OR IN SOME OTHER
14 COMMUNITY-BASED SETTING IF HOME- OR COMMUNITY-BASED SERVICES WERE
15 AVAILABLE TO THE APPLICANT; TO PROVIDE THAT IF THE DIVISION
16 DETERMINES THAT A HOME- OR OTHER COMMUNITY-BASED SETTING IS
17 APPROPRIATE AND COST-EFFECTIVE, IT SHALL ADVISE THE APPLICANT THAT
18 A HOME- OR OTHER COMMUNITY-BASED SETTING IS APPROPRIATE AND
19 PROVIDE A PROPOSED CARE PLAN FOR THE APPLICANT; TO PROVIDE THAT
20 THE DIVISION MAY PROVIDE THE SERVICES FOR THE APPLICANT DIRECTLY
21 OR THROUGH CONTRACT WITH CASE MANAGERS FROM THE LOCAL AREA
22 AGENCIES ON AGING; TO PROVIDE THAT THE DIVISION SHALL EXPAND
23 HOME- AND COMMUNITY-BASED SERVICES OVER A FIVE-YEAR PERIOD; TO
24 DELETE THE REQUIREMENT THAT THE DIVISION PROVIDE HOME- AND
25 COMMUNITY-BASED SERVICES UNDER A COOPERATIVE AGREEMENT WITH THE
26 DEPARTMENT OF HUMAN SERVICES; TO AMEND SECTION 41-7-191,
27 MISSISSIPPI CODE OF 1972, TO DELETE THE RESTRICTIONS ON
28 PARTICIPATION IN THE MEDICAID PROGRAM FOR NURSING HOME BEDS THAT
29 WERE AUTHORIZED BY CERTIFICATES OF NEED; TO EXTEND THE PERIOD OF
30 TIME FOR THE ISSUANCE OF CERTIFICATES OF NEED FOR NURSING FACILITY
31 BEDS IN CERTAIN COUNTIES; TO PROVIDE THAT THE STATE DEPARTMENT OF
32 HEALTH SHALL ISSUE CERTIFICATES OF NEED DURING EACH OF THE NEXT
33 FOUR FISCAL YEARS FOR THE CONSTRUCTION OR EXPANSION OF NURSING
34 FACILITY BEDS IN EACH COUNTY IN THE STATE HAVING A NEED FOR 50 OR
35 MORE ADDITIONAL NURSING FACILITY BEDS, NOT TO EXCEED 60 BEDS FOR
36 EACH CERTIFICATE OF NEED; TO PROVIDE THAT DURING EACH OF THE NEXT
37 FOUR FISCAL YEARS, THE DEPARTMENT SHALL ISSUE SIX CERTIFICATES OF
38 NEED FOR NEW NURSING FACILITY BEDS, WITH ONE CERTIFICATE OF NEED
39 TO BE ISSUED FOR NEW BEDS IN THE COUNTY IN EACH OF THE FOUR
40 LONG-TERM CARE PLANNING DISTRICTS DESIGNATED IN THE STATE HEALTH
41 PLAN THAT HAS THE HIGHEST NEED IN THE DISTRICT FOR THOSE BEDS, AND
42 TWO CERTIFICATES OF NEED TO BE ISSUED FOR NEW BEDS IN THE TWO
43 COUNTIES FROM THE STATE AT LARGE THAT HAVE THE HIGHEST NEED IN THE
44 STATE FOR THOSE BEDS; TO PROVIDE THAT DURING FISCAL YEAR 2000, THE
45 DEPARTMENT ALSO SHALL ISSUE A CERTIFICATE OF NEED FOR NEW NURSING
46 FACILITY BEDS IN AMITE COUNTY AND A CERTIFICATE OF NEED FOR NEW
47 NURSING FACILITY BEDS IN CARROLL COUNTY; TO PROVIDE THAT THE
48 CERTIFICATE OF NEED ISSUED IN EACH DISTRICT DURING EACH FISCAL
49 YEAR SHALL FIRST BE AVAILABLE FOR NURSING FACILITY BEDS IN THE
50 COUNTY IN THE DISTRICT HAVING THE HIGHEST NEED FOR THOSE BEDS; TO
51 PROVIDE THAT IF THERE ARE NO APPLICATIONS FOR A CERTIFICATE OF
52 NEED IN THE COUNTY HAVING THE HIGHEST NEED, THEN THE CERTIFICATE

53 OF NEED SHALL BE AVAILABLE FOR NURSING FACILITY BEDS IN OTHER
54 COUNTIES IN THE DISTRICT IN DESCENDING ORDER OF THE NEED FOR THOSE
55 BEDS, UNTIL AN APPLICATION IS RECEIVED FOR BEDS IN AN ELIGIBLE
56 COUNTY IN THE DISTRICT; TO PROVIDE THAT AFTER A CERTIFICATE OF
57 NEED HAS BEEN ISSUED FOR NURSING FACILITY BEDS IN A COUNTY DURING
58 ANY FISCAL YEAR OF THE FOUR-YEAR PERIOD, A CERTIFICATE OF NEED
59 SHALL NOT BE AVAILABLE AGAIN FOR ADDITIONAL BEDS IN THAT COUNTY
60 DURING THE FOUR-YEAR PERIOD; TO PROVIDE THAT THE DEPARTMENT SHALL
61 ISSUE CERTIFICATES OF NEED DURING THE NEXT TWO FISCAL YEARS FOR
62 THE CONSTRUCTION OR CONVERSION OF NURSING FACILITY BEDS IN EACH OF
63 THE FOUR LONG-TERM CARE PLANNING DISTRICTS TO PROVIDE CARE
64 EXCLUSIVELY TO PATIENTS WITH ALZHEIMER'S DISEASE, NOT TO EXCEED 20
65 BEDS PER CERTIFICATE OF NEED OR A TOTAL OF 60 BEDS PER DISTRICT;
66 TO PROVIDE THAT THE TOTAL NUMBER OF THOSE BEDS SHALL NOT EXCEED
67 120 BEDS DURING ANY FISCAL YEAR, AND THE TOTAL NUMBER OF THOSE
68 BEDS IN ANY DISTRICT SHALL NOT EXCEED 40 BEDS DURING ANY FISCAL
69 YEAR; TO DIRECT THE STATE DEPARTMENT OF HEALTH TO DEVELOP AND
70 PRESCRIBE STANDARDS AND REQUIREMENTS THAT MUST BE MET WITH REGARD
71 TO THOSE NURSING FACILITY BEDS FOR ALZHEIMER'S PATIENTS; TO
72 AUTHORIZE THE STATE DEPARTMENT OF HEALTH TO ISSUE CERTIFICATES OF
73 NEED FOR THE CONSTRUCTION OR EXPANSION OF CHILD PSYCHIATRIC BEDS
74 AT THE UNIVERSITY MEDICAL CENTER; TO PROVIDE THAT NOTHING IN THE
75 CERTIFICATE OF NEED LAW SHALL PREVENT ANY NURSING FACILITY FROM
76 DESIGNATING EXISTING BEDS IN THE FACILITY AS BEDS FOR PROVIDING
77 CARE EXCLUSIVELY TO PATIENTS WITH ALZHEIMER'S DISEASE; AND FOR
78 RELATED PURPOSES.

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

80 SECTION 1. Section 43-13-117, Mississippi Code of 1972, as
81 amended by House Bill No. 57 and House Bill No. 403, 1999 Regular
82 Session, is amended as follows:

83 43-13-117. Medical assistance as authorized by this article
84 shall include payment of part or all of the costs, at the
85 discretion of the division or its successor, with approval of the
86 Governor, of the following types of care and services rendered to
87 eligible applicants who shall have been determined to be eligible
88 for such care and services, within the limits of state
89 appropriations and federal matching funds:

90 (1) Inpatient hospital services.

91 (a) The division shall allow thirty (30) days of
92 inpatient hospital care annually for all Medicaid recipients;
93 however, before any recipient will be allowed more than fifteen
94 (15) days of inpatient hospital care in any one (1) year, he must
95 obtain prior approval therefor from the division. The division
96 shall be authorized to allow unlimited days in disproportionate
97 hospitals as defined by the division for eligible infants under
98 the age of six (6) years.

99 (b) From and after July 1, 1994, the Executive Director
100 of the Division of Medicaid shall amend the Mississippi Title XIX
101 Inpatient Hospital Reimbursement Plan to remove the occupancy rate
102 penalty from the calculation of the Medicaid Capital Cost
103 Component utilized to determine total hospital costs allocated to
104 the Medicaid Program.
105 (2) Outpatient hospital services. Provided that where the
106 same services are reimbursed as clinic services, the division may
107 revise the rate or methodology of outpatient reimbursement to
108 maintain consistency, efficiency, economy and quality of care.
109 (3) Laboratory and x-ray services.
110 (4) Nursing facility services.
111 (a) The division shall make full payment to nursing
112 facilities for each day, not exceeding fifty-two (52) days per
113 year, that a patient is absent from the facility on home leave.
114 However, before payment may be made for more than eighteen (18)
115 home leave days in a year for a patient, the patient must have
116 written authorization from a physician stating that the patient is
117 physically and mentally able to be away from the facility on home
118 leave. Such authorization must be filed with the division before
119 it will be effective and the authorization shall be effective for
120 three (3) months from the date it is received by the division,
121 unless it is revoked earlier by the physician because of a change
122 in the condition of the patient.
123 (b) From and after July 1, 1993, the division shall
124 implement the integrated case-mix payment and quality monitoring
125 system developed pursuant to Section 43-13-122, which includes the
126 fair rental system for property costs and in which recapture of
127 depreciation is eliminated. The division may revise the
128 reimbursement methodology for the case-mix payment system by
129 reducing payment for hospital leave and therapeutic home leave
130 days to the lowest case-mix category for nursing facilities,
131 modifying the current method of scoring residents so that only
132 services provided at the nursing facility are considered in

133 calculating a facility's per diem, and the division may limit
134 administrative and operating costs, but in no case shall these
135 costs be less than one hundred nine percent (109%) of the median
136 administrative and operating costs for each class of facility, not
137 to exceed the median used to calculate the nursing facility
138 reimbursement for Fiscal Year 1996, to be applied uniformly to all
139 long-term care facilities. This paragraph (b) shall stand
140 repealed on July 1, 1997.

141 (c) From and after July 1, 1997, all state-owned
142 nursing facilities shall be reimbursed on a full reasonable costs
143 basis. From and after July 1, 1997, payments by the division to
144 nursing facilities for return on equity capital shall be made at
145 the rate paid under Medicare (Title XVIII of the Social Security
146 Act), but shall be no less than seven and one-half percent (7.5%)
147 nor greater than ten percent (10%).

148 (d) A Review Board for nursing facilities is
149 established to conduct reviews of the Division of Medicaid's
150 decision in the areas set forth below:

151 (i) Review shall be heard in the following areas:

152 (A) Matters relating to cost reports
153 including, but not limited to, allowable costs and cost
154 adjustments resulting from desk reviews and audits.

155 (B) Matters relating to the Minimum Data Set
156 Plus (MDS +) or successor assessment formats including, but not
157 limited to, audits, classifications and submissions.

158 (ii) The Review Board shall be composed of six (6)
159 members, three (3) having expertise in one (1) of the two (2)
160 areas set forth above and three (3) having expertise in the other
161 area set forth above. Each panel of three (3) shall only review
162 appeals arising in its area of expertise. The members shall be
163 appointed as follows:

164 (A) In each of the areas of expertise defined
165 under subparagraphs (i)(A) and (i)(B), the Executive Director of
166 the Division of Medicaid shall appoint one (1) person chosen from

167 the private sector nursing home industry in the state, which may
168 include independent accountants and consultants serving the
169 industry;

170 (B) In each of the areas of expertise defined
171 under subparagraphs (i)(A) and (i)(B), the Executive Director of
172 the Division of Medicaid shall appoint one (1) person who is
173 employed by the state who does not participate directly in desk
174 reviews or audits of nursing facilities in the two (2) areas of
175 review;

176 (C) The two (2) members appointed by the
177 Executive Director of the Division of Medicaid in each area of
178 expertise shall appoint a third member in the same area of
179 expertise.

180 In the event of a conflict of interest on the part of any
181 Review Board members, the Executive Director of the Division of
182 Medicaid or the other two (2) panel members, as applicable, shall
183 appoint a substitute member for conducting a specific review.

184 (iii) The Review Board panels shall have the power
185 to preserve and enforce order during hearings; to issue subpoenas;
186 to administer oaths; to compel attendance and testimony of
187 witnesses; or to compel the production of books, papers, documents
188 and other evidence; or the taking of depositions before any
189 designated individual competent to administer oaths; to examine
190 witnesses; and to do all things conformable to law that may be
191 necessary to enable it effectively to discharge its duties. The
192 Review Board panels may appoint such person or persons as they
193 shall deem proper to execute and return process in connection
194 therewith.

195 (iv) The Review Board shall promulgate, publish
196 and disseminate to nursing facility providers rules of procedure
197 for the efficient conduct of proceedings, subject to the approval
198 of the Executive Director of the Division of Medicaid and in
199 accordance with federal and state administrative hearing laws and
200 regulations.

201 (v) Proceedings of the Review Board shall be of
202 record.
203 (vi) Appeals to the Review Board shall be in
204 writing and shall set out the issues, a statement of alleged facts
205 and reasons supporting the provider's position. Relevant
206 documents may also be attached. The appeal shall be filed within
207 thirty (30) days from the date the provider is notified of the
208 action being appealed or, if informal review procedures are taken,
209 as provided by administrative regulations of the Division of
210 Medicaid, within thirty (30) days after a decision has been
211 rendered through informal hearing procedures.
212 (vii) The provider shall be notified of the
213 hearing date by certified mail within thirty (30) days from the
214 date the Division of Medicaid receives the request for appeal.
215 Notification of the hearing date shall in no event be less than
216 thirty (30) days before the scheduled hearing date. The appeal
217 may be heard on shorter notice by written agreement between the
218 provider and the Division of Medicaid.
219 (viii) Within thirty (30) days from the date of
220 the hearing, the Review Board panel shall render a written
221 recommendation to the Executive Director of the Division of
222 Medicaid setting forth the issues, findings of fact and applicable
223 law, regulations or provisions.
224 (ix) The Executive Director of the Division of
225 Medicaid shall, upon review of the recommendation, the proceedings
226 and the record, prepare a written decision which shall be mailed
227 to the nursing facility provider no later than twenty (20) days
228 after the submission of the recommendation by the panel. The
229 decision of the executive director is final, subject only to
230 judicial review.
231 (x) Appeals from a final decision shall be made to
232 the Chancery Court of Hinds County. The appeal shall be filed
233 with the court within thirty (30) days from the date the decision
234 of the Executive Director of the Division of Medicaid becomes

235 final.

236 (xi) The action of the Division of Medicaid under
237 review shall be stayed until all administrative proceedings have
238 been exhausted.

239 (xii) Appeals by nursing facility providers
240 involving any issues other than those two (2) specified in
241 subparagraphs (i)(A) and (ii)(B) shall be taken in accordance with
242 the administrative hearing procedures established by the Division
243 of Medicaid.

244 (e) The Division of Medicaid shall develop and
245 implement a referral process for long-term care alternatives for
246 Medicaid beneficiaries and applicants. No Medicaid beneficiary
247 shall be admitted to a Medicaid-certified nursing facility unless
248 a licensed physician certifies that nursing facility care is
249 appropriate for that person on a standardized form to be prepared
250 and provided to nursing facilities by the Division of Medicaid.
251 The physician shall forward a copy of that certification to the
252 Division of Medicaid within twenty-four (24) hours after it is
253 signed by the physician. Any physician who fails to forward the
254 certification to the Division of Medicaid within the time period
255 specified in this paragraph shall be ineligible for Medicaid
256 reimbursement for any physician's services performed for the
257 applicant. The Division of Medicaid shall determine, through an
258 assessment of the applicant conducted within two (2) business days
259 after receipt of the physician's certification, whether the
260 applicant also could live appropriately and cost-effectively at
261 home or in some other community-based setting if home- or
262 community-based services were available to the applicant. The
263 time limitation prescribed in this paragraph shall be waived in
264 cases of emergency. If the Division of Medicaid determines that a
265 home- or other community-based setting is appropriate and
266 cost-effective, the division shall:

267 (i) Advise the applicant or the applicant's legal
268 representative that a home- or other community-based setting is

269 appropriate;

270 (ii) Provide a proposed care plan and inform the
271 applicant or the applicant's legal representative regarding the
272 degree to which the services in the care plan are available in a
273 home- or in other community-based setting rather than nursing
274 facility care; and

275 (iii) Explain that such plan and services are
276 available only if the applicant or the applicant's legal
277 representative chooses a home- or community-based alternative to
278 nursing facility care, and that the applicant is free to choose
279 nursing facility care.

280 The Division of Medicaid may provide the services described
281 in this paragraph (e) directly or through contract with case
282 managers from the local Area Agencies on Aging, and shall
283 coordinate long-term care alternatives to avoid duplication with
284 hospital discharge planning procedures.

285 Placement in a nursing facility may not be denied by the
286 division if home- or community-based services that would be more
287 appropriate than nursing facility care are not actually available,
288 or if the applicant chooses not to receive the appropriate home-
289 or community-based services.

290 The division shall provide an opportunity for a fair hearing
291 under federal regulations to any applicant who is not given the
292 choice of home- or community-based services as an alternative to
293 institutional care.

294 The division shall make full payment for long-term care
295 alternative services.

296 The division shall apply for necessary federal waivers to
297 assure that additional services providing alternatives to nursing
298 facility care are made available to applicants for nursing
299 facility care.

300 (f) When a facility of a category that does not require
301 a certificate of need for construction and that could not be
302 eligible for Medicaid reimbursement is constructed to nursing

303 facility specifications for licensure and certification, and the
304 facility is subsequently converted to a nursing facility pursuant
305 to a certificate of need that authorizes conversion only and the
306 applicant for the certificate of need was assessed an application
307 review fee based on capital expenditures incurred in constructing
308 the facility, the division shall allow reimbursement for capital
309 expenditures necessary for construction of the facility that were
310 incurred within the twenty-four (24) consecutive calendar months
311 immediately preceding the date that the certificate of need
312 authorizing such conversion was issued, to the same extent that
313 reimbursement would be allowed for construction of a new nursing
314 facility pursuant to a certificate of need that authorizes such
315 construction. The reimbursement authorized in this subparagraph
316 (f) may be made only to facilities the construction of which was
317 completed after June 30, 1989. Before the division shall be
318 authorized to make the reimbursement authorized in this
319 subparagraph (f), the division first must have received approval
320 from the Health Care Financing Administration of the United States
321 Department of Health and Human Services of the change in the state
322 Medicaid plan providing for such reimbursement.
323 (5) Periodic screening and diagnostic services for
324 individuals under age twenty-one (21) years as are needed to
325 identify physical and mental defects and to provide health care
326 treatment and other measures designed to correct or ameliorate
327 defects and physical and mental illness and conditions discovered
328 by the screening services regardless of whether these services are
329 included in the state plan. The division may include in its
330 periodic screening and diagnostic program those discretionary
331 services authorized under the federal regulations adopted to
332 implement Title XIX of the federal Social Security Act, as
333 amended. The division, in obtaining physical therapy services,
334 occupational therapy services, and services for individuals with
335 speech, hearing and language disorders, may enter into a
336 cooperative agreement with the State Department of Education for

337 the provision of such services to handicapped students by public
338 school districts using state funds which are provided from the
339 appropriation to the Department of Education to obtain federal
340 matching funds through the division. The division, in obtaining
341 medical and psychological evaluations for children in the custody
342 of the State Department of Human Services may enter into a
343 cooperative agreement with the State Department of Human Services
344 for the provision of such services using state funds which are
345 provided from the appropriation to the Department of Human
346 Services to obtain federal matching funds through the division.
347 On July 1, 1993, all fees for periodic screening and
348 diagnostic services under this paragraph (5) shall be increased by
349 twenty-five percent (25%) of the reimbursement rate in effect on
350 June 30, 1993.
351 (6) Physicians' services. On January 1, 1996, all fees for
352 physicians' services shall be reimbursed at seventy percent (70%)
353 of the rate established on January 1, 1994, under Medicare (Title
354 XVIII of the Social Security Act, as amended), and the division
355 may adjust the physicians' reimbursement schedule to reflect the
356 differences in relative value between Medicaid and Medicare.
357 (7) (a) Home health services for eligible persons, not to
358 exceed in cost the prevailing cost of nursing facility services,
359 not to exceed sixty (60) visits per year.
360 (b) The division may revise reimbursement for home
361 health services in order to establish equity between reimbursement
362 for home health services and reimbursement for institutional
363 services within the Medicaid program. This paragraph (b) shall
364 stand repealed on July 1, 1997.
365 (8) Emergency medical transportation services. On January
366 1, 1994, emergency medical transportation services shall be
367 reimbursed at seventy percent (70%) of the rate established under
368 Medicare (Title XVIII of the Social Security Act, as amended).
369 "Emergency medical transportation services" shall mean, but shall
370 not be limited to, the following services by a properly permitted

371 ambulance operated by a properly licensed provider in accordance
372 with the Emergency Medical Services Act of 1974 (Section 41-59-1
373 et seq.): (i) basic life support, (ii) advanced life support,
374 (iii) mileage, (iv) oxygen, (v) intravenous fluids, (vi)
375 disposable supplies, (vii) similar services.

376 (9) Legend and other drugs as may be determined by the
377 division. The division may implement a program of prior approval
378 for drugs to the extent permitted by law. Payment by the division
379 for covered multiple source drugs shall be limited to the lower of
380 the upper limits established and published by the Health Care
381 Financing Administration (HCFA) plus a dispensing fee of Four
382 Dollars and Ninety-one Cents ($4.91), or the estimated acquisition
383 cost (EAC) as determined by the division plus a dispensing fee of
384 Four Dollars and Ninety-one Cents ($4.91), or the providers' usual
385 and customary charge to the general public. The division shall
386 allow five (5) prescriptions per month for noninstitutionalized
387 Medicaid recipients; however, exceptions for up to ten (10)
388 prescriptions per month shall be allowed, with the approval of the
389 director.

390 Payment for other covered drugs, other than multiple source
391 drugs with HCFA upper limits, shall not exceed the lower of the
392 estimated acquisition cost as determined by the division plus a
393 dispensing fee of Four Dollars and Ninety-one Cents ($4.91) or the
394 providers' usual and customary charge to the general public.

395 Payment for nonlegend or over-the-counter drugs covered on
396 the division's formulary shall be reimbursed at the lower of the
397 division's estimated shelf price or the providers' usual and
398 customary charge to the general public. No dispensing fee shall
399 be paid.

400 The division shall develop and implement a program of payment
401 for additional pharmacist services, with payment to be based on
402 demonstrated savings, but in no case shall the total payment
403 exceed twice the amount of the dispensing fee.

404 As used in this paragraph (9), "estimated acquisition cost"

405 means the division's best estimate of what price providers
406 generally are paying for a drug in the package size that providers
407 buy most frequently. Product selection shall be made in
408 compliance with existing state law; however, the division may
409 reimburse as if the prescription had been filled under the generic
410 name. The division may provide otherwise in the case of specified
411 drugs when the consensus of competent medical advice is that
412 trademarked drugs are substantially more effective.
413 (10) Dental care that is an adjunct to treatment of an acute
414 medical or surgical condition; services of oral surgeons and
415 dentists in connection with surgery related to the jaw or any
416 structure contiguous to the jaw or the reduction of any fracture
417 of the jaw or any facial bone; and emergency dental extractions
418 and treatment related thereto. On January 1, 1994, all fees for
419 dental care and surgery under authority of this paragraph (10)
420 shall be increased by twenty percent (20%) of the reimbursement
421 rate as provided in the Dental Services Provider Manual in effect
422 on December 31, 1993.
423 (11) Eyeglasses necessitated by reason of eye surgery, and
424 as prescribed by a physician skilled in diseases of the eye or an
425 optometrist, whichever the patient may select.
426 (12) Intermediate care facility services.
427 (a) The division shall make full payment to all
428 intermediate care facilities for the mentally retarded for each
429 day, not exceeding eighty-four (84) days per year, that a patient
430 is absent from the facility on home leave. Payment may be made
431 for the following home leave days in addition to the
432 eighty-four-day limitation: Christmas, the day before Christmas,
433 the day after Christmas, Thanksgiving, the day before Thanksgiving
434 and the day after Thanksgiving. However, before payment may be
435 made for more than eighteen (18) home leave days in a year for a
436 patient, the patient must have written authorization from a
437 physician stating that the patient is physically and mentally able
438 to be away from the facility on home leave. Such authorization

439 must be filed with the division before it will be effective, and
440 the authorization shall be effective for three (3) months from the
441 date it is received by the division, unless it is revoked earlier
442 by the physician because of a change in the condition of the
443 patient.

444 (b) All state-owned intermediate care facilities for
445 the mentally retarded shall be reimbursed on a full reasonable
446 cost basis.

447 (13) Family planning services, including drugs, supplies and
448 devices, when such services are under the supervision of a
449 physician.

450 (14) Clinic services. Such diagnostic, preventive,
451 therapeutic, rehabilitative or palliative services furnished to an
452 outpatient by or under the supervision of a physician or dentist
453 in a facility which is not a part of a hospital but which is
454 organized and operated to provide medical care to outpatients.
455 Clinic services shall include any services reimbursed as
456 outpatient hospital services which may be rendered in such a
457 facility, including those that become so after July 1, 1991. On
458 January 1, 1994, all fees for physicians' services reimbursed
459 under authority of this paragraph (14) shall be reimbursed at
460 seventy percent (70%) of the rate established on January 1, 1993,
461 under Medicare (Title XVIII of the Social Security Act, as
462 amended), or the amount that would have been paid under the
463 division's fee schedule that was in effect on December 31, 1993,
464 whichever is greater, and the division may adjust the physicians'
465 reimbursement schedule to reflect the differences in relative
466 value between Medicaid and Medicare. However, on January 1, 1994,
467 the division may increase any fee for physicians' services in the
468 division's fee schedule on December 31, 1993, that was greater
469 than seventy percent (70%) of the rate established under Medicare
470 by no more than ten percent (10%). On January 1, 1994, all fees
471 for dentists' services reimbursed under authority of this
472 paragraph (14) shall be increased by twenty percent (20%) of the

473 reimbursement rate as provided in the Dental Services Provider
474 Manual in effect on December 31, 1993.
475 (15) Home- and community-based services, as provided under
476 Title XIX of the federal Social Security Act, as amended, under
477 waivers, subject to the availability of funds specifically
478 appropriated therefor by the Legislature. Payment for such
479 services shall be limited to individuals who would be eligible for
480 and would otherwise require the level of care provided in a
481 nursing facility. <u>The home- and community-based services</u>
482 <u>authorized under this paragraph shall be expanded over a five-year</u>
483 <u>period beginning July 1, 1999.</u> The division shall certify case
484 management agencies to provide case management services and
485 provide for home- and community-based services for eligible
486 individuals under this paragraph. The home- and community-based
487 services under this paragraph and the activities performed by
488 certified case management agencies under this paragraph shall be
489 funded using state funds that are provided from the appropriation
490 to the Division of Medicaid and used to match federal funds *** * ***.
491 (16) Mental health services. Approved therapeutic and case
492 management services provided by (a) an approved regional mental
493 health/retardation center established under Sections 41-19-31
494 through 41-19-39, or by another community mental health service
495 provider meeting the requirements of the Department of Mental
496 Health to be an approved mental health/retardation center if
497 determined necessary by the Department of Mental Health, using
498 state funds which are provided from the appropriation to the State
499 Department of Mental Health and used to match federal funds under
500 a cooperative agreement between the division and the department,
501 or (b) a facility which is certified by the State Department of
502 Mental Health to provide therapeutic and case management services,
503 to be reimbursed on a fee for service basis. Any such services
504 provided by a facility described in paragraph (b) must have the
505 prior approval of the division to be reimbursable under this
506 section. After June 30, 1997, mental health services provided by

507 regional mental health/retardation centers established under
508 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
509 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
510 psychiatric residential treatment facilities as defined in Section
511 43-11-1, or by another community mental health service provider
512 meeting the requirements of the Department of Mental Health to be
513 an approved mental health/retardation center if determined
514 necessary by the Department of Mental Health, shall not be
515 included in or provided under any capitated managed care pilot
516 program provided for under paragraph (24) of this section.
517 (17) Durable medical equipment services and medical supplies
518 restricted to patients receiving home health services unless
519 waived on an individual basis by the division. The division shall
520 not expend more than Three Hundred Thousand Dollars ($300,000.00)
521 of state funds annually to pay for medical supplies authorized
522 under this paragraph.
523 (18) Notwithstanding any other provision of this section to
524 the contrary, the division shall make additional reimbursement to
525 hospitals which serve a disproportionate share of low-income
526 patients and which meet the federal requirements for such payments
527 as provided in Section 1923 of the federal Social Security Act and
528 any applicable regulations.
529 (19) (a) Perinatal risk management services. The division
530 shall promulgate regulations to be effective from and after
531 October 1, 1988, to establish a comprehensive perinatal system for
532 risk assessment of all pregnant and infant Medicaid recipients and
533 for management, education and follow-up for those who are
534 determined to be at risk. Services to be performed include case
535 management, nutrition assessment/counseling, psychosocial
536 assessment/counseling and health education. The division shall
537 set reimbursement rates for providers in conjunction with the
538 State Department of Health.
539 (b) Early intervention system services. The division
540 shall cooperate with the State Department of Health, acting as

541 lead agency, in the development and implementation of a statewide
542 system of delivery of early intervention services, pursuant to
543 Part H of the Individuals with Disabilities Education Act (IDEA).
544 The State Department of Health shall certify annually in writing
545 to the director of the division the dollar amount of state early
546 intervention funds available which shall be utilized as a
547 certified match for Medicaid matching funds. Those funds then
548 shall be used to provide expanded targeted case management
549 services for Medicaid eligible children with special needs who are
550 eligible for the state's early intervention system.
551 Qualifications for persons providing service coordination shall be
552 determined by the State Department of Health and the Division of
553 Medicaid.

554 (20) Home- and community-based services for physically
555 disabled approved services as allowed by a waiver from the United
556 States Department of Health and Human Services for home- and
557 community-based services for physically disabled people using
558 state funds which are provided from the appropriation to the State
559 Department of Rehabilitation Services and used to match federal
560 funds under a cooperative agreement between the division and the
561 department, provided that funds for these services are
562 specifically appropriated to the Department of Rehabilitation
563 Services.

564 (21) Nurse practitioner services. Services furnished by a
565 registered nurse who is licensed and certified by the Mississippi
566 Board of Nursing as a nurse practitioner including, but not
567 limited to, nurse anesthetists, nurse midwives, family nurse
568 practitioners, family planning nurse practitioners, pediatric
569 nurse practitioners, obstetrics-gynecology nurse practitioners and
570 neonatal nurse practitioners, under regulations adopted by the
571 division. Reimbursement for such services shall not exceed ninety
572 percent (90%) of the reimbursement rate for comparable services
573 rendered by a physician.

574 (22) Ambulatory services delivered in federally qualified

575 health centers and in clinics of the local health departments of
576 the State Department of Health for individuals eligible for
577 medical assistance under this article based on reasonable costs as
578 determined by the division.

579 (23) Inpatient psychiatric services. Inpatient psychiatric
580 services to be determined by the division for recipients under age
581 twenty-one (21) which are provided under the direction of a
582 physician in an inpatient program in a licensed acute care
583 psychiatric facility or in a licensed psychiatric residential
584 treatment facility, before the recipient reaches age twenty-one
585 (21) or, if the recipient was receiving the services immediately
586 before he reached age twenty-one (21), before the earlier of the
587 date he no longer requires the services or the date he reaches age
588 twenty-two (22), as provided by federal regulations. Recipients
589 shall be allowed forty-five (45) days per year of psychiatric
590 services provided in acute care psychiatric facilities, and shall
591 be allowed unlimited days of psychiatric services provided in
592 licensed psychiatric residential treatment facilities.

593 (24) Managed care services in a program to be developed by
594 the division by a public or private provider. Notwithstanding any
595 other provision in this article to the contrary, the division
596 shall establish rates of reimbursement to providers rendering care
597 and services authorized under this section, and may revise such
598 rates of reimbursement without amendment to this section by the
599 Legislature for the purpose of achieving effective and accessible
600 health services, and for responsible containment of costs. This
601 shall include, but not be limited to, one (1) module of capitated
602 managed care in a rural area, and one (1) module of capitated
603 managed care in an urban area.

604 (25) Birthing center services.

605 (26) Hospice care. As used in this paragraph, the term
606 "hospice care" means a coordinated program of active professional
607 medical attention within the home and outpatient and inpatient
608 care which treats the terminally ill patient and family as a unit,

609 employing a medically directed interdisciplinary team. The
610 program provides relief of severe pain or other physical symptoms
611 and supportive care to meet the special needs arising out of
612 physical, psychological, spiritual, social and economic stresses
613 which are experienced during the final stages of illness and
614 during dying and bereavement and meets the Medicare requirements
615 for participation as a hospice as provided in 42 CFR Part 418.
616 (27) Group health plan premiums and cost sharing if it is
617 cost effective as defined by the Secretary of Health and Human
618 Services.
619 (28) Other health insurance premiums which are cost
620 effective as defined by the Secretary of Health and Human
621 Services. Medicare eligible must have Medicare Part B before
622 other insurance premiums can be paid.
623 (29) The Division of Medicaid may apply for a waiver from
624 the Department of Health and Human Services for home- and
625 community-based services for developmentally disabled people using
626 state funds which are provided from the appropriation to the State
627 Department of Mental Health and used to match federal funds under
628 a cooperative agreement between the division and the department,
629 provided that funds for these services are specifically
630 appropriated to the Department of Mental Health.
631 (30) Pediatric skilled nursing services for eligible persons
632 under twenty-one (21) years of age.
633 (31) Targeted case management services for children with
634 special needs, under waivers from the United States Department of
635 Health and Human Services, using state funds that are provided
636 from the appropriation to the Mississippi Department of Human
637 Services and used to match federal funds under a cooperative
638 agreement between the division and the department.
639 (32) Care and services provided in Christian Science
640 Sanatoria operated by or listed and certified by The First Church
641 of Christ Scientist, Boston, Massachusetts, rendered in connection
642 with treatment by prayer or spiritual means to the extent that

643 such services are subject to reimbursement under Section 1903 of
644 the Social Security Act.
645 (33) Podiatrist services.
646 (34) Personal care services provided in a pilot program to
647 not more than forty (40) residents at a location or locations to
648 be determined by the division and delivered by individuals
649 qualified to provide such services, as allowed by waivers under
650 Title XIX of the Social Security Act, as amended. The division
651 shall not expend more than Three Hundred Thousand Dollars
652 ($300,000.00) annually to provide such personal care services.
653 The division shall develop recommendations for the effective
654 regulation of any facilities that would provide personal care
655 services which may become eligible for Medicaid reimbursement
656 under this section, and shall present such recommendations with
657 any proposed legislation to the 1996 Regular Session of the
658 Legislature on or before January 1, 1996.
659 (35) Services and activities authorized in Sections
660 43-27-101 and 43-27-103, using state funds that are provided from
661 the appropriation to the State Department of Human Services and
662 used to match federal funds under a cooperative agreement between
663 the division and the department.
664 (36) Nonemergency transportation services for
665 Medicaid-eligible persons, to be provided by the Department of
666 Human Services. The division may contract with additional
667 entities to administer nonemergency transportation services as it
668 deems necessary. All providers shall have a valid driver's
669 license, vehicle inspection sticker and a standard liability
670 insurance policy covering the vehicle.
671 (37) Targeted case management services for individuals with
672 chronic diseases, with expanded eligibility to cover services to
673 uninsured recipients, on a pilot program basis. This paragraph
674 (37) shall be contingent upon continued receipt of special funds
675 from the Health Care Financing Authority and private foundations
676 who have granted funds for planning these services. No funding

677 for these services shall be provided from State General Funds.
678 (38) Chiropractic services: a chiropractor's manual
679 manipulation of the spine to correct a subluxation, if x-ray
680 demonstrates that a subluxation exists and if the subluxation has
681 resulted in a neuromusculoskeletal condition for which
682 manipulation is appropriate treatment. Reimbursement for
683 chiropractic services shall not exceed Seven Hundred Dollars
684 ($700.00) per year per recipient.
685 Notwithstanding any provision of this article, except as
686 authorized in the following paragraph and in Section 43-13-139,
687 neither (a) the limitations on quantity or frequency of use of or
688 the fees or charges for any of the care or services available to
689 recipients under this section, nor (b) the payments or rates of
690 reimbursement to providers rendering care or services authorized
691 under this section to recipients, may be increased, decreased or
692 otherwise changed from the levels in effect on July 1, 1986,
693 unless such is authorized by an amendment to this section by the
694 Legislature. However, the restriction in this paragraph shall not
695 prevent the division from changing the payments or rates of
696 reimbursement to providers without an amendment to this section
697 whenever such changes are required by federal law or regulation,
698 or whenever such changes are necessary to correct administrative
699 errors or omissions in calculating such payments or rates of
700 reimbursement.
701 Notwithstanding any provision of this article, no new groups
702 or categories of recipients and new types of care and services may
703 be added without enabling legislation from the Mississippi
704 Legislature, except that the division may authorize such changes
705 without enabling legislation when such addition of recipients or
706 services is ordered by a court of proper authority. The director
707 shall keep the Governor advised on a timely basis of the funds
708 available for expenditure and the projected expenditures. In the
709 event current or projected expenditures can be reasonably
710 anticipated to exceed the amounts appropriated for any fiscal

711 year, the Governor, after consultation with the director, shall
712 discontinue any or all of the payment of the types of care and
713 services as provided herein which are deemed to be optional
714 services under Title XIX of the federal Social Security Act, as
715 amended, for any period necessary to not exceed appropriated
716 funds, and when necessary shall institute any other cost
717 containment measures on any program or programs authorized under
718 the article to the extent allowed under the federal law governing
719 such program or programs, it being the intent of the Legislature
720 that expenditures during any fiscal year shall not exceed the
721 amounts appropriated for such fiscal year.

722 SECTION 2. Section 41-7-191, Mississippi Code of 1972, as
723 amended by Senate Bill No. 2486, 1999 Regular Session, is amended
724 as follows:

725 41-7-191. (1) No person shall engage in any of the
726 following activities without obtaining the required certificate of
727 need:

728 (a) The construction, development or other
729 establishment of a new health care facility;

730 (b) The relocation of a health care facility or portion
731 thereof, or major medical equipment;

732 (c) A change over a period of two (2) years' time, as
733 established by the State Department of Health, in existing bed
734 complement through the addition of more than ten (10) beds or more
735 than ten percent (10%) of the total bed capacity of a designated
736 licensed category or subcategory of any health care facility,
737 whichever is less, from one physical facility or site to another;
738 the conversion over a period of two (2) years' time, as
739 established by the State Department of Health, of existing bed
740 complement of more than ten (10) beds or more than ten percent
741 (10%) of the total bed capacity of a designated licensed category
742 or subcategory of any such health care facility, whichever is
743 less; or the alteration, modernizing or refurbishing of any unit
744 or department wherein such beds may be located; provided, however,

745 that from and after July 1, 1994, no health care facility shall be
746 authorized to add any beds or convert any beds to another category
747 of beds without a certificate of need under the authority of
748 subsection (1)(c) of this section unless there is a projected need
749 for such beds in the planning district in which the facility is
750 located, as reported in the most current State Health Plan;
751 (d) Offering of the following health services if those
752 services have not been provided on a regular basis by the proposed
753 provider of such services within the period of twelve (12) months
754 prior to the time such services would be offered:
755 (i) Open heart surgery services;
756 (ii) Cardiac catheterization services;
757 (iii) Comprehensive inpatient rehabilitation
758 services;
759 (iv) Licensed psychiatric services;
760 (v) Licensed chemical dependency services;
761 (vi) Radiation therapy services;
762 (vii) Diagnostic imaging services of an invasive
763 nature, i.e. invasive digital angiography;
764 (viii) Nursing home care as defined in
765 subparagraphs (iv), (vi) and (viii) of Section 41-7-173(h);
766 (ix) Home health services;
767 (x) Swing-bed services;
768 (xi) Ambulatory surgical services;
769 (xii) Magnetic resonance imaging services;
770 (xiii) Extracorporeal shock wave lithotripsy
771 services;
772 (xiv) Long-term care hospital services;
773 (xv) Positron Emission Tomography (PET) Services;
774 (e) The relocation of one or more health services from
775 one physical facility or site to another physical facility or
776 site, unless such relocation, which does not involve a capital
777 expenditure by or on behalf of a health care facility, is the
778 result of an order of a court of appropriate jurisdiction or a

779 result of pending litigation in such court, or by order of the
780 State Department of Health, or by order of any other agency or
781 legal entity of the state, the federal government, or any
782 political subdivision of either, whose order is also approved by
783 the State Department of Health;

784 (f) The acquisition or otherwise control of any major
785 medical equipment for the provision of medical services; provided,
786 however, that the acquisition of any major medical equipment used
787 only for research purposes shall be exempt from this paragraph; an
788 acquisition for less than fair market value must be reviewed, if
789 the acquisition at fair market value would be subject to review;

790 (g) Changes of ownership of existing health care
791 facilities in which a notice of intent is not filed with the State
792 Department of Health at least thirty (30) days prior to the date
793 such change of ownership occurs, or a change in services or bed
794 capacity as prescribed in paragraph (c) or (d) of this subsection
795 as a result of the change of ownership; an acquisition for less
796 than fair market value must be reviewed, if the acquisition at
797 fair market value would be subject to review;

798 (h) The change of ownership of any health care facility
799 defined in subparagraphs (iv), (vi) and (viii) of Section
800 41-7-173(h), in which a notice of intent as described in paragraph
801 (g) has not been filed and if the Executive Director, Division of
802 Medicaid, Office of the Governor, has not certified in writing
803 that there will be no increase in allowable costs to Medicaid from
804 revaluation of the assets or from increased interest and
805 depreciation as a result of the proposed change of ownership;

806 (i) Any activity described in paragraphs (a) through
807 (h) if undertaken by any person if that same activity would
808 require certificate of need approval if undertaken by a health
809 care facility;

810 (j) Any capital expenditure or deferred capital
811 expenditure by or on behalf of a health care facility not covered
812 by paragraphs (a) through (h);

813 (k) The contracting of a health care facility as
814 defined in subparagraphs (i) through (viii) of Section 41-7-173(h)
815 to establish a home office, subunit, or branch office in the space
816 operated as a health care facility through a formal arrangement
817 with an existing health care facility as defined in subparagraph
818 (ix) of Section 41-7-173(h).
819 (2) The State Department of Health shall not grant approval
820 for or issue a certificate of need to any person proposing the new
821 construction of, addition to, or expansion of any health care
822 facility defined in subparagraphs (iv) (skilled nursing facility)
823 and (vi) (intermediate care facility) of Section 41-7-173(h) or
824 the conversion of vacant hospital beds to provide skilled or
825 intermediate nursing home care, except as hereinafter authorized:
826 * * *
827 <u>(a)</u> The department may issue a certificate of need to
828 any person proposing the new construction of any health care
829 facility defined in subparagraphs (iv) and (vi) of Section
830 41-7-173(h) as part of a life care retirement facility, in any
831 county bordering on the Gulf of Mexico in which is located a
832 National Aeronautics and Space Administration facility, not to
833 exceed forty (40) beds<u>. From and after July 1, 1999, there shall</u>
834 <u>be no prohibition or restrictions on participation in the Medicaid</u>
835 <u>program (Section 43-13-101 et seq.) for the beds in the health</u>
836 <u>care facility that were authorized under this paragraph (a).</u>
837 * * *
838 <u>(b)</u> The department may issue certificates of need in
839 Harrison County to provide skilled nursing home care for
840 Alzheimer's Disease patients and other patients, not to exceed one
841 hundred fifty (150) beds<u>. From and after July 1, 1999, there</u>
842 <u>shall be no prohibition or restrictions on participation in the</u>
843 <u>Medicaid program (Section 43-13-101 et seq.) for the beds in the</u>
844 <u>nursing facilities that were authorized under this paragraph (b).</u>
845 * * *
846 <u>(c)</u> The department may issue a certificate of need for

847 the addition to or expansion of any skilled nursing facility that
848 is part of an existing continuing care retirement community
849 located in Madison County, provided that the recipient of the
850 certificate of need agrees in writing that the skilled nursing
851 facility will not at any time participate in the Medicaid program
852 (Section 43-13-101 et seq.) or admit or keep any patients in the
853 skilled nursing facility who are participating in the Medicaid
854 program. This written agreement by the recipient of the
855 certificate of need shall be fully binding on any subsequent owner
856 of the skilled nursing facility, if the ownership of the facility
857 is transferred at any time after the issuance of the certificate
858 of need. Agreement that the skilled nursing facility will not
859 participate in the Medicaid program shall be a condition of the
860 issuance of a certificate of need to any person under this
861 paragraph <u>(c)</u>, and if such skilled nursing facility at any time
862 after the issuance of the certificate of need, regardless of the
863 ownership of the facility, participates in the Medicaid program or
864 admits or keeps any patients in the facility who are participating
865 in the Medicaid program, the State Department of Health shall
866 revoke the certificate of need, if it is still outstanding, and
867 shall deny or revoke the license of the skilled nursing facility,
868 at the time that the department determines, after a hearing
869 complying with due process, that the facility has failed to comply
870 with any of the conditions upon which the certificate of need was
871 issued, as provided in this paragraph and in the written agreement
872 by the recipient of the certificate of need. The total number of
873 beds that may be authorized under the authority of this paragraph
874 <u>(c)</u> shall not exceed sixty (60) beds.
875 <u>(d)</u> The State Department of Health may issue a
876 certificate of need to any hospital located in DeSoto County for
877 the new construction of a skilled nursing facility, not to exceed
878 one hundred twenty (120) beds, in DeSoto County<u>. From and after</u>
879 <u>July 1, 1999, there shall be no prohibition or restrictions on</u>
880 <u>participation in the Medicaid program (Section 43-13-101 et seq.)</u>

881 for the beds in the nursing facility that were authorized under
882 this paragraph (d).
883 (e) The State Department of Health may issue a
884 certificate of need for the construction of a nursing facility or
885 the conversion of beds to nursing facility beds at a personal care
886 facility for the elderly in Lowndes County that is owned and
887 operated by a Mississippi nonprofit corporation, not to exceed
888 sixty (60) beds. From and after July 1, 1999, there shall be no
889 prohibition or restrictions on participation in the Medicaid
890 program (Section 43-13-101 et seq.) for the beds in the nursing
891 facility that were authorized under this paragraph (e).
892 (f) The State Department of Health may issue a
893 certificate of need for conversion of a county hospital facility
894 in Itawamba County to a nursing facility, not to exceed sixty (60)
895 beds, including any necessary construction, renovation or
896 expansion. From and after July 1, 1999, there shall be no
897 prohibition or restrictions on participation in the Medicaid
898 program (Section 43-13-101 et seq.) for the beds in the nursing
899 facility that were authorized under this paragraph (f).
900 (g) The State Department of Health may issue a
901 certificate of need for the construction or expansion of nursing
902 facility beds or the conversion of other beds to nursing facility
903 beds in either Hinds, Madison or Rankin Counties, not to exceed
904 sixty (60) beds. From and after July 1, 1999, there shall be no
905 prohibition or restrictions on participation in the Medicaid
906 program (Section 43-13-101 et seq.) for the beds in the nursing
907 facility that were authorized under this paragraph (g).
908 (h) The State Department of Health may issue a
909 certificate of need for the construction or expansion of nursing
910 facility beds or the conversion of other beds to nursing facility
911 beds in either Hancock, Harrison or Jackson Counties, not to
912 exceed sixty (60) beds. From and after July 1, 1999, there shall
913 be no prohibition or restrictions on participation in the Medicaid
914 program (Section 43-13-101 et seq.) for the beds in the facility

915 <u>that were authorized under this paragraph (h).</u>

916 <u>(i)</u> The department may issue a certificate of need for
917 the new construction of a skilled nursing facility in Leake
918 County, provided that the recipient of the certificate of need
919 agrees in writing that the skilled nursing facility will not at
920 any time participate in the Medicaid program (Section 43-13-101 et
921 seq.) or admit or keep any patients in the skilled nursing
922 facility who are participating in the Medicaid program. This
923 written agreement by the recipient of the certificate of need
924 shall be fully binding on any subsequent owner of the skilled
925 nursing facility, if the ownership of the facility is transferred
926 at any time after the issuance of the certificate of need.
927 Agreement that the skilled nursing facility will not participate
928 in the Medicaid program shall be a condition of the issuance of a
929 certificate of need to any person under this paragraph <u>(i)</u>, and if
930 such skilled nursing facility at any time after the issuance of
931 the certificate of need, regardless of the ownership of the
932 facility, participates in the Medicaid program or admits or keeps
933 any patients in the facility who are participating in the Medicaid
934 program, the State Department of Health shall revoke the
935 certificate of need, if it is still outstanding, and shall deny or
936 revoke the license of the skilled nursing facility, at the time
937 that the department determines, after a hearing complying with due
938 process, that the facility has failed to comply with any of the
939 conditions upon which the certificate of need was issued, as
940 provided in this paragraph and in the written agreement by the
941 recipient of the certificate of need. The provision of Section
942 43-7-193(1) regarding substantial compliance of the projection of
943 need as reported in the current State Health Plan is waived for
944 the purposes of this paragraph. The total number of nursing
945 facility beds that may be authorized by any certificate of need
946 issued under this paragraph <u>(i)</u> shall not exceed sixty (60) beds.
947 If the skilled nursing facility authorized by the certificate of
948 need issued under this paragraph is not constructed and fully

949 operational within eighteen (18) months after July 1, 1994, the
950 State Department of Health, after a hearing complying with due
951 process, shall revoke the certificate of need, if it is still
952 outstanding, and shall not issue a license for the skilled nursing
953 facility at any time after the expiration of the eighteen-month
954 period.
955 * * *
956 (j) The department may issue certificates of need to
957 allow any existing freestanding long-term care facility in
958 Tishomingo County and Hancock County that on July 1, 1995, is
959 licensed with fewer than sixty (60) beds. * * * For the purposes
960 of this paragraph (j), the provision of Section 41-7-193(1)
961 requiring substantial compliance with the projection of need as
962 reported in the current State Health Plan is waived. From and
963 after July 1, 1999, there shall be no prohibition or restrictions
964 on participation in the Medicaid program (Section 43-13-101 et
965 seq.) for the beds in the long-term care facilities that were
966 authorized under this paragraph (j).
967 (k) The department may issue a certificate of need for
968 the construction of a nursing facility at a continuing care
969 retirement community in Lowndes County, provided that the
970 recipient of the certificate of need agrees in writing that the
971 nursing facility will not at any time participate in the Medicaid
972 program (Section 43-13-101 et seq.) or admit or keep any patients
973 in the nursing facility who are participating in the Medicaid
974 program. This written agreement by the recipient of the
975 certificate of need shall be fully binding on any subsequent owner
976 of the nursing facility, if the ownership of the facility is
977 transferred at any time after the issuance of the certificate of
978 need. Agreement that the nursing facility will not participate in
979 the Medicaid program shall be a condition of the issuance of a
980 certificate of need to any person under this paragraph (k), and if
981 such nursing facility at any time after the issuance of the
982 certificate of need, regardless of the ownership of the facility,

983 participates in the Medicaid program or admits or keeps any
984 patients in the facility who are participating in the Medicaid
985 program, the State Department of Health shall revoke the
986 certificate of need, if it is still outstanding, and shall deny or
987 revoke the license of the nursing facility, at the time that the
988 department determines, after a hearing complying with due process,
989 that the facility has failed to comply with any of the conditions
990 upon which the certificate of need was issued, as provided in this
991 paragraph and in the written agreement by the recipient of the
992 certificate of need. The total number of beds that may be
993 authorized under the authority of this paragraph (k) shall not
994 exceed sixty (60) beds.

995 (l) Provided that funds are specifically appropriated
996 therefor by the Legislature, the department may issue a
997 certificate of need to a rehabilitation hospital in Hinds County
998 for the construction of a sixty-bed long-term care nursing
999 facility dedicated to the care and treatment of persons with
1000 severe disabilities including persons with spinal cord and
1001 closed-head injuries and ventilator-dependent patients. The
1002 provision of Section 41-7-193(1) regarding substantial compliance
1003 with projection of need as reported in the current State Health
1004 Plan is hereby waived for the purpose of this paragraph.

1005 (m) The State Department of Health may issue a
1006 certificate of need to a county-owned hospital in the Second
1007 Judicial District of Panola County for the conversion of not more
1008 than seventy-two (72) hospital beds to nursing facility beds,
1009 provided that the recipient of the certificate of need agrees in
1010 writing that none of the beds at the nursing facility will be
1011 certified for participation in the Medicaid program (Section
1012 43-13-101 et seq.), and that no claim will be submitted for
1013 Medicaid reimbursement in the nursing facility in any day or for
1014 any patient in the nursing facility. This written agreement by
1015 the recipient of the certificate of need shall be a condition of
1016 the issuance of the certificate of need under this paragraph, and

1017 the agreement shall be fully binding on any subsequent owner of
1018 the nursing facility if the ownership of the nursing facility is
1019 transferred at any time after the issuance of the certificate of
1020 need. After this written agreement is executed, the Division of
1021 Medicaid and the State Department of Health shall not certify any
1022 of the beds in the nursing facility for participation in the
1023 Medicaid program. If the nursing facility violates the terms of
1024 the written agreement by admitting or keeping in the nursing
1025 facility on a regular or continuing basis any patients who are
1026 participating in the Medicaid program, the State Department of
1027 Health shall revoke the license of the nursing facility, at the
1028 time that the department determines, after a hearing complying
1029 with due process, that the nursing facility has violated the
1030 condition upon which the certificate of need was issued, as
1031 provided in this paragraph and in the written agreement. If the
1032 certificate of need authorized under this paragraph is not issued
1033 within twelve (12) months after July 1, 2001, the department shall
1034 deny the application for the certificate of need and shall not
1035 issue the certificate of need at any time after the twelve-month
1036 period, unless the issuance is contested. If the certificate of
1037 need is issued and substantial construction of the nursing
1038 facility beds has not commenced within eighteen (18) months after
1039 July 1, 2001, the State Department of Health, after a hearing
1040 complying with due process, shall revoke the certificate of need
1041 if it is still outstanding, and the department shall not issue a
1042 license for the nursing facility at any time after the
1043 eighteen-month period. Provided, however, that if the issuance of
1044 the certificate of need is contested, the department shall require
1045 substantial construction of the nursing facility beds within six
1046 (6) months after final adjudication on the issuance of the
1047 certificate of need.
1048 (n) The department may issue a certificate of need for
1049 the new construction, addition or conversion of skilled nursing
1050 facility beds in Madison County, provided that the recipient of

1051 the certificate of need agrees in writing that the skilled nursing
1052 facility will not at any time participate in the Medicaid program
1053 (Section 43-13-101 et seq.) or admit or keep any patients in the
1054 skilled nursing facility who are participating in the Medicaid
1055 program. This written agreement by the recipient of the
1056 certificate of need shall be fully binding on any subsequent owner
1057 of the skilled nursing facility, if the ownership of the facility
1058 is transferred at any time after the issuance of the certificate
1059 of need. Agreement that the skilled nursing facility will not
1060 participate in the Medicaid program shall be a condition of the
1061 issuance of a certificate of need to any person under this
1062 paragraph (n), and if such skilled nursing facility at any time
1063 after the issuance of the certificate of need, regardless of the
1064 ownership of the facility, participates in the Medicaid program or
1065 admits or keeps any patients in the facility who are participating
1066 in the Medicaid program, the State Department of Health shall
1067 revoke the certificate of need, if it is still outstanding, and
1068 shall deny or revoke the license of the skilled nursing facility,
1069 at the time that the department determines, after a hearing
1070 complying with due process, that the facility has failed to comply
1071 with any of the conditions upon which the certificate of need was
1072 issued, as provided in this paragraph and in the written agreement
1073 by the recipient of the certificate of need. The total number of
1074 nursing facility beds that may be authorized by any certificate of
1075 need issued under this paragraph (n) shall not exceed sixty (60)
1076 beds. If the certificate of need authorized under this paragraph
1077 is not issued within twelve (12) months after July 1, 1998, the
1078 department shall deny the application for the certificate of need
1079 and shall not issue the certificate of need at any time after the
1080 twelve-month period, unless the issuance is contested. If the
1081 certificate of need is issued and substantial construction of the
1082 nursing facility beds has not commenced within eighteen (18)
1083 months after the effective date of July 1, 1998, the State
1084 Department of Health, after a hearing complying with due process,

1085 shall revoke the certificate of need if it is still outstanding,
1086 and the department shall not issue a license for the nursing
1087 facility at any time after the eighteen-month period. Provided,
1088 however, that if the issuance of the certificate of need is
1089 contested, the department shall require substantial construction
1090 of the nursing facility beds within six (6) months after final
1091 adjudication on the issuance of the certificate of need.

1092 (o) The department may issue a certificate of need for
1093 the new construction, addition or conversion of skilled nursing
1094 facility beds in Leake County, provided that the recipient of the
1095 certificate of need agrees in writing that the skilled nursing
1096 facility will not at any time participate in the Medicaid program
1097 (Section 43-13-101 et seq.) or admit or keep any patients in the
1098 skilled nursing facility who are participating in the Medicaid
1099 program. This written agreement by the recipient of the
1100 certificate of need shall be fully binding on any subsequent owner
1101 of the skilled nursing facility, if the ownership of the facility
1102 is transferred at any time after the issuance of the certificate
1103 of need. Agreement that the skilled nursing facility will not
1104 participate in the Medicaid program shall be a condition of the
1105 issuance of a certificate of need to any person under this
1106 paragraph (o), and if such skilled nursing facility at any time
1107 after the issuance of the certificate of need, regardless of the
1108 ownership of the facility, participates in the Medicaid program or
1109 admits or keeps any patients in the facility who are participating
1110 in the Medicaid program, the State Department of Health shall
1111 revoke the certificate of need, if it is still outstanding, and
1112 shall deny or revoke the license of the skilled nursing facility,
1113 at the time that the department determines, after a hearing
1114 complying with due process, that the facility has failed to comply
1115 with any of the conditions upon which the certificate of need was
1116 issued, as provided in this paragraph and in the written agreement
1117 by the recipient of the certificate of need. The total number of
1118 nursing facility beds that may be authorized by any certificate of

1119 need issued under this paragraph (o) shall not exceed sixty (60)
1120 beds. If the certificate of need authorized under this paragraph
1121 is not issued within twelve (12) months after July 1, 2001, the
1122 department shall deny the application for the certificate of need
1123 and shall not issue the certificate of need at any time after the
1124 twelve-month period, unless the issuance is contested. If the
1125 certificate of need is issued and substantial construction of the
1126 nursing facility beds has not commenced within eighteen (18)
1127 months after the effective date of July 1, 2001, the State
1128 Department of Health, after a hearing complying with due process,
1129 shall revoke the certificate of need if it is still outstanding,
1130 and the department shall not issue a license for the nursing
1131 facility at any time after the eighteen-month period. Provided,
1132 however, that if the issuance of the certificate of need is
1133 contested, the department shall require substantial construction
1134 of the nursing facility beds within six (6) months after final
1135 adjudication on the issuance of the certificate of need.
1136 (p) The department may issue a certificate of need for
1137 the construction of a municipally-owned nursing facility within
1138 the Town of Belmont in Tishomingo County, not to exceed sixty (60)
1139 beds, provided that the recipient of the certificate of need
1140 agrees in writing that the skilled nursing facility will not at
1141 any time participate in the Medicaid program (Section 43-13-101 et
1142 seq.) or admit or keep any patients in the skilled nursing
1143 facility who are participating in the Medicaid program. This
1144 written agreement by the recipient of the certificate of need
1145 shall be fully binding on any subsequent owner of the skilled
1146 nursing facility, if the ownership of the facility is transferred
1147 at any time after the issuance of the certificate of need.
1148 Agreement that the skilled nursing facility will not participate
1149 in the Medicaid program shall be a condition of the issuance of a
1150 certificate of need to any person under this paragraph (p), and if
1151 such skilled nursing facility at any time after the issuance of
1152 the certificate of need, regardless of the ownership of the

1153 facility, participates in the Medicaid program or admits or keeps
1154 any patients in the facility who are participating in the Medicaid
1155 program, the State Department of Health shall revoke the
1156 certificate of need, if it is still outstanding, and shall deny or
1157 revoke the license of the skilled nursing facility, at the time
1158 that the department determines, after a hearing complying with due
1159 process, that the facility has failed to comply with any of the
1160 conditions upon which the certificate of need was issued, as
1161 provided in this paragraph and in the written agreement by the
1162 recipient of the certificate of need. The provision of Section
1163 43-7-193(1) regarding substantial compliance of the projection of
1164 need as reported in the current State Health Plan is waived for
1165 the purposes of this paragraph. If the certificate of need
1166 authorized under this paragraph is not issued within twelve (12)
1167 months after July 1, 1998, the department shall deny the
1168 application for the certificate of need and shall not issue the
1169 certificate of need at any time after the twelve-month period,
1170 unless the issuance is contested. If the certificate of need is
1171 issued and substantial construction of the nursing facility beds
1172 has not commenced within eighteen (18) months after July 1, 1998,
1173 the State Department of Health, after a hearing complying with due
1174 process, shall revoke the certificate of need if it is still
1175 outstanding, and the department shall not issue a license for the
1176 nursing facility at any time after the eighteen-month period.
1177 Provided, however, that if the issuance of the certificate of need
1178 is contested, the department shall require substantial
1179 construction of the nursing facility beds within six (6) months
1180 after final adjudication on the issuance of the certificate of
1181 need.
1182 (q) (i) Beginning on July 1, 1999, the State
1183 Department of Health shall issue certificates of need during each
1184 of the next four (4) fiscal years for the construction or
1185 expansion of nursing facility beds or the conversion of other beds
1186 to nursing facility beds in each county in the state having a need

1187 for fifty (50) or more additional nursing facility beds, as shown
1188 in the Fiscal Year 1999 State Health Plan, in the manner provided
1189 in this paragraph (q). The total number of nursing facility beds
1190 that may be authorized by any certificate of need authorized under
1191 this paragraph (q) shall not exceed sixty (60) beds.
1192 (ii) Subject to the provisions of subparagraph
1193 (v), during each of the next four (4) fiscal years, the department
1194 shall issue six (6) certificates of need for new nursing facility
1195 beds, as follows: During Fiscal Years 2000, 2001 and 2002, one
1196 (1) certificate of need shall be issued for new nursing facility
1197 beds in the county in each of the four (4) Long-Term Care Planning
1198 Districts designated in the Fiscal Year 1999 State Health Plan
1199 that has the highest need in the district for those beds; and two
1200 (2) certificates of need shall be issued for new nursing facility
1201 beds in the two (2) counties from the state at large that have the
1202 highest need in the state for those beds, when considering the
1203 need on a statewide basis and without regard to the Long-Term Care
1204 Planning Districts in which the counties are located. During
1205 Fiscal Year 2003, one (1) certificate of need shall be issued for
1206 new nursing facility beds in any county having a need for fifty
1207 (50) or more additional nursing facility beds, as shown in the
1208 Fiscal Year 1999 State Health Plan, that has not received a
1209 certificate of need under this paragraph (q) during the three (3)
1210 previous fiscal years. During Fiscal Year 2000, in addition to
1211 the six (6) certificates of need authorized in this subparagraph,
1212 the department also shall issue a certificate of need for new
1213 nursing facility beds in Amite County and a certificate of need
1214 for new nursing facility beds in Carroll County.
1215 (iii) Subject to the provisions of subparagraph
1216 (v), the certificate of need issued under subparagraph (ii) for
1217 nursing facility beds in each Long-Term Care Planning District
1218 during each fiscal year shall first be available for nursing
1219 facility beds in the county in the district having the highest
1220 need for those beds, as shown in the Fiscal Year 1999 State Health

1221 Plan. If there are no applications for a certificate of need for
1222 nursing facility beds in the county having the highest need for
1223 those beds by the date specified by the department, then the
1224 certificate of need shall be available for nursing facility beds
1225 in other counties in the district in descending order of the need
1226 for those beds, from the county with the second highest need to
1227 the county with the lowest need, until an application is received
1228 for nursing facility beds in an eligible county in the district.
1229 (iv) Subject to the provisions of subparagraph
1230 (v), the certificate of need issued under subparagraph (ii) for
1231 nursing facility beds in the two (2) counties from the state at
1232 large during each fiscal year shall first be available for nursing
1233 facility beds in the two (2) counties that have the highest need
1234 in the state for those beds, as shown in the Fiscal Year 1999
1235 State Health Plan, when considering the need on a statewide basis
1236 and without regard to the Long-Term Care Planning Districts in
1237 which the counties are located. If there are no applications for
1238 a certificate of need for nursing facility beds in either of the
1239 two (2) counties having the highest need for those beds on a
1240 statewide basis by the date specified by the department, then the
1241 certificate of need shall be available for nursing facility beds
1242 in other counties from the state at large in descending order of
1243 the need for those beds on a statewide basis, from the county with
1244 the second highest need to the county with the lowest need, until
1245 an application is received for nursing facility beds in an
1246 eligible county from the state at large.
1247 (v) If a certificate of need is authorized to be
1248 issued under this paragraph (q) for nursing facility beds in a
1249 county on the basis of the need in the Long-Term Care Planning
1250 District during any fiscal year of the four-year period, a
1251 certificate of need shall not also be available under this
1252 paragraph (q) for additional nursing facility beds in that county
1253 on the basis of the need in the state at large, and that county
1254 shall be excluded in determining which counties have the highest

1255 need for nursing facility beds in the state at large for that
1256 fiscal year. After a certificate of need has been issued under
1257 this paragraph (q) for nursing facility beds in a county during
1258 any fiscal year of the four-year period, a certificate of need
1259 shall not be available again under this paragraph (q) for
1260 additional nursing facility beds in that county during the
1261 four-year period, and that county shall be excluded in determining
1262 which counties have the highest need for nursing facility beds in
1263 succeeding fiscal years.
1264 (r) (i) Beginning on July 1, 1999, the State
1265 Department of Health shall issue certificates of need during each
1266 of the next two (2) fiscal years for the construction or expansion
1267 of nursing facility beds or the conversion of other beds to
1268 nursing facility beds in each of the four (4) Long-Term Care
1269 Planning Districts designated in the Fiscal Year 1999 State Health
1270 Plan, to provide care exclusively to patients with Alzheimer's
1271 disease.
1272 (ii) Not more than twenty (20) beds may be
1273 authorized by any certificate of need issued under this paragraph
1274 (r), and not more than a total of sixty (60) beds may be
1275 authorized in any Long-Term Care Planning District by all
1276 certificates of need issued under this paragraph (r). However,
1277 the total number of beds that may be authorized by all
1278 certificates of need issued under this paragraph (r) during any
1279 fiscal year shall not exceed one hundred twenty (120) beds, and
1280 the total number of beds that may be authorized in any Long-Term
1281 Care Planning District during any fiscal year shall not exceed
1282 forty (40) beds. Of the certificates of need that are issued for
1283 each Long-Term Care Planning District during the next two (2)
1284 fiscal years, at least one (1) shall be issued for beds in the
1285 northern part of the district, at least one (1) shall be issued
1286 for beds in the central part of the district, and at least one (1)
1287 shall be issued for beds in the southern part of the district.
1288 (iii) The State Department of Health, in

1289 consultation with the Department of Mental Health and the Division
1290 of Medicaid, shall develop and prescribe the staffing levels,
1291 space requirements and other standards and requirements that must
1292 be met with regard to the nursing facility beds authorized under
1293 this paragraph (r) to provide care exclusively to patients with
1294 Alzheimer's disease.

1295 *** * ***

1296 (3) The State Department of Health may grant approval for
1297 and issue certificates of need to any person proposing the new
1298 construction of, addition to, conversion of beds of or expansion
1299 of any health care facility defined in subparagraph (x)
1300 (psychiatric residential treatment facility) of Section
1301 41-7-173(h). The total number of beds which may be authorized by
1302 such certificates of need shall not exceed two hundred
1303 seventy-four (274) beds for the entire state.

1304 (a) Of the total number of beds authorized under this
1305 subsection, the department shall issue a certificate of need to a
1306 privately owned psychiatric residential treatment facility in
1307 Simpson County for the conversion of sixteen (16) intermediate
1308 care facility for the mentally retarded (ICF-MR) beds to
1309 psychiatric residential treatment facility beds, provided that
1310 facility agrees in writing that the facility shall give priority
1311 for the use of those sixteen (16) beds to Mississippi residents
1312 who are presently being treated in out-of-state facilities.

1313 (b) Of the total number of beds authorized under this
1314 subsection, the department may issue a certificate or certificates
1315 of need for the construction or expansion of psychiatric
1316 residential treatment facility beds or the conversion of other
1317 beds to psychiatric residential treatment facility beds in Warren
1318 County, not to exceed sixty (60) psychiatric residential treatment
1319 facility beds, provided that the facility agrees in writing that
1320 no more than thirty (30) of the beds at the psychiatric
1321 residential treatment facility will be certified for participation
1322 in the Medicaid program (Section 43-13-101 et seq.) for the use of

1323 any patients other than those who are participating only in the
1324 Medicaid program of another state, and that no claim will be
1325 submitted to the Division of Medicaid for Medicaid reimbursement
1326 for more than thirty (30) patients in the psychiatric residential
1327 treatment facility in any day or for any patient in the
1328 psychiatric residential treatment facility who is in a bed that is
1329 not Medicaid-certified. This written agreement by the recipient
1330 of the certificate of need shall be a condition of the issuance of
1331 the certificate of need under this paragraph, and the agreement
1332 shall be fully binding on any subsequent owner of the psychiatric
1333 residential treatment facility if the ownership of the facility is
1334 transferred at any time after the issuance of the certificate of
1335 need. After this written agreement is executed, the Division of
1336 Medicaid and the State Department of Health shall not certify more
1337 than thirty (30) of the beds in the psychiatric residential
1338 treatment facility for participation in the Medicaid program for
1339 the use of any patients other than those who are participating
1340 only in the Medicaid program of another state. If the psychiatric
1341 residential treatment facility violates the terms of the written
1342 agreement by admitting or keeping in the facility on a regular or
1343 continuing basis more than thirty (30) patients who are
1344 participating in the Mississippi Medicaid program, the State
1345 Department of Health shall revoke the license of the facility, at
1346 the time that the department determines, after a hearing complying
1347 with due process, that the facility has violated the condition
1348 upon which the certificate of need was issued, as provided in this
1349 paragraph and in the written agreement.
1350 (c) Of the total number of beds authorized under this
1351 subsection, the department shall issue a certificate of need to a
1352 hospital currently operating Medicaid-certified acute psychiatric
1353 beds for adolescents in DeSoto County, for the establishment of a
1354 forty-bed psychiatric residential treatment facility in DeSoto
1355 County, provided that the hospital agrees in writing (i) that the
1356 hospital shall give priority for the use of those forty (40) beds

1357 to Mississippi residents who are presently being treated in
1358 out-of-state facilities, and (ii) that no more than fifteen (15)
1359 of the beds at the psychiatric residential treatment facility will
1360 be certified for participation in the Medicaid program (Section
1361 43-13-101 et seq.), and that no claim will be submitted for
1362 Medicaid reimbursement for more than fifteen (15) patients in the
1363 psychiatric residential treatment facility in any day or for any
1364 patient in the psychiatric residential treatment facility who is
1365 in a bed that is not Medicaid-certified. This written agreement
1366 by the recipient of the certificate of need shall be a condition
1367 of the issuance of the certificate of need under this paragraph,
1368 and the agreement shall be fully binding on any subsequent owner
1369 of the psychiatric residential treatment facility if the ownership
1370 of the facility is transferred at any time after the issuance of
1371 the certificate of need. After this written agreement is
1372 executed, the Division of Medicaid and the State Department of
1373 Health shall not certify more than fifteen (15) of the beds in the
1374 psychiatric residential treatment facility for participation in
1375 the Medicaid program. If the psychiatric residential treatment
1376 facility violates the terms of the written agreement by admitting
1377 or keeping in the facility on a regular or continuing basis more
1378 than fifteen (15) patients who are participating in the Medicaid
1379 program, the State Department of Health shall revoke the license
1380 of the facility, at the time that the department determines, after
1381 a hearing complying with due process, that the facility has
1382 violated the condition upon which the certificate of need was
1383 issued, as provided in this paragraph and in the written
1384 agreement.
1385 (d) Of the total number of beds authorized under this
1386 subsection, the department may issue a certificate or certificates
1387 of need for the construction or expansion of psychiatric
1388 residential treatment facility beds or the conversion of other
1389 beds to psychiatric treatment facility beds, not to exceed thirty
1390 (30) psychiatric residential treatment facility beds, in either

1391 Alcorn, Tishomingo, Prentiss, Lee, Itawamba, Monroe, Chickasaw,
1392 Pontotoc, Calhoun, Lafayette, Union, Benton or Tippah Counties.
1393 (e) Of the total number of beds authorized under this
1394 subsection (3) the department shall issue a certificate of need to
1395 a privately owned, nonprofit psychiatric residential treatment
1396 facility in Hinds County for an eight-bed expansion of the
1397 facility, provided that the facility agrees in writing that the
1398 facility shall give priority for the use of those eight (8) beds
1399 to Mississippi residents who are presently being treated in
1400 out-of-state facilities.
1401 (4) (a) From and after July 1, 1993, the department shall
1402 not issue a certificate of need to any person for the new
1403 construction of any hospital, psychiatric hospital or chemical
1404 dependency hospital that will contain any child/adolescent
1405 psychiatric or child/adolescent chemical dependency beds, or for
1406 the conversion of any other health care facility to a hospital,
1407 psychiatric hospital or chemical dependency hospital that will
1408 contain any child/adolescent psychiatric or child/adolescent
1409 chemical dependency beds, or for the addition of any
1410 child/adolescent psychiatric or child/adolescent chemical
1411 dependency beds in any hospital, psychiatric hospital or chemical
1412 dependency hospital, or for the conversion of any beds of another
1413 category in any hospital, psychiatric hospital or chemical
1414 dependency hospital to child/adolescent psychiatric or
1415 child/adolescent chemical dependency beds, except as hereinafter
1416 authorized:
1417 (i) The department may issue certificates of need
1418 to any person for any purpose described in this subsection,
1419 provided that the hospital, psychiatric hospital or chemical
1420 dependency hospital does not participate in the Medicaid program
1421 (Section 43-13-101 et seq.) at the time of the application for the
1422 certificate of need and the owner of the hospital, psychiatric
1423 hospital or chemical dependency hospital agrees in writing that
1424 the hospital, psychiatric hospital or chemical dependency hospital

1425 will not at any time participate in the Medicaid program or admit
1426 or keep any patients who are participating in the Medicaid program
1427 in the hospital, psychiatric hospital or chemical dependency
1428 hospital. This written agreement by the recipient of the
1429 certificate of need shall be fully binding on any subsequent owner
1430 of the hospital, psychiatric hospital or chemical dependency
1431 hospital, if the ownership of the facility is transferred at any
1432 time after the issuance of the certificate of need. Agreement
1433 that the hospital, psychiatric hospital or chemical dependency
1434 hospital will not participate in the Medicaid program shall be a
1435 condition of the issuance of a certificate of need to any person
1436 under this subparagraph (a)(i), and if such hospital, psychiatric
1437 hospital or chemical dependency hospital at any time after the
1438 issuance of the certificate of need, regardless of the ownership
1439 of the facility, participates in the Medicaid program or admits or
1440 keeps any patients in the hospital, psychiatric hospital or
1441 chemical dependency hospital who are participating in the Medicaid
1442 program, the State Department of Health shall revoke the
1443 certificate of need, if it is still outstanding, and shall deny or
1444 revoke the license of the hospital, psychiatric hospital or
1445 chemical dependency hospital, at the time that the department
1446 determines, after a hearing complying with due process, that the
1447 hospital, psychiatric hospital or chemical dependency hospital has
1448 failed to comply with any of the conditions upon which the
1449 certificate of need was issued, as provided in this subparagraph
1450 and in the written agreement by the recipient of the certificate
1451 of need.
1452 (ii) The department may issue a certificate of
1453 need for the conversion of existing beds in a county hospital in
1454 Choctaw County from acute care beds to child/adolescent chemical
1455 dependency beds. For purposes of this subparagraph, the
1456 provisions of Section 41-7-193(1) requiring substantial compliance
1457 with the projection of need as reported in the current State
1458 Health Plan is waived. The total number of beds that may be

1459 authorized under authority of this subparagraph shall not exceed
1460 twenty (20) beds. There shall be no prohibition or restrictions
1461 on participation in the Medicaid program (Section 43-13-101 et
1462 seq.) for the hospital receiving the certificate of need
1463 authorized under this subparagraph (a)(ii) or for the beds
1464 converted pursuant to the authority of that certificate of need.
1465 (iii) The department may issue a certificate or
1466 certificates of need for the construction or expansion of
1467 child/adolescent psychiatric beds or the conversion of other beds
1468 to child/adolescent psychiatric beds in Warren County. For
1469 purposes of this subparagraph, the provisions of Section
1470 41-7-193(1) requiring substantial compliance with the projection
1471 of need as reported in the current State Health Plan are waived.
1472 The total number of beds that may be authorized under the
1473 authority of this subparagraph shall not exceed twenty (20) beds.
1474 There shall be no prohibition or restrictions on participation in
1475 the Medicaid program (Section 43-13-101 et seq.) for the person
1476 receiving the certificate of need authorized under this
1477 subparagraph (a)(iii) or for the beds converted pursuant to the
1478 authority of that certificate of need.
1479 (iv) The department shall issue a certificate of
1480 need to the Region 7 Mental Health/Retardation Commission for the
1481 construction or expansion of child/adolescent psychiatric beds or
1482 the conversion of other beds to child/adolescent psychiatric beds
1483 in any of the counties served by the commission. For purposes of
1484 this subparagraph, the provisions of Section 41-7-193(1) requiring
1485 substantial compliance with the projection of need as reported in
1486 the current State Health Plan is waived. The total number of beds
1487 that may be authorized under the authority of this subparagraph
1488 shall not exceed twenty (20) beds. There shall be no prohibition
1489 or restrictions on participation in the Medicaid program (Section
1490 43-13-101 et seq.) for the person receiving the certificate of
1491 need authorized under this subparagraph (a)(iv) or for the beds
1492 converted pursuant to the authority of that certificate of need.

1493 (v) The department may issue a certificate of need
1494 to any county hospital located in Leflore County for the
1495 construction or expansion of adult psychiatric beds or the
1496 conversion of other beds to adult psychiatric beds, not to exceed
1497 twenty (20) beds, provided that the recipient of the certificate
1498 of need agrees in writing that the adult psychiatric beds will not
1499 at any time be certified for participation in the Medicaid program
1500 and that the hospital will not admit or keep any patients who are
1501 participating in the Medicaid program in any of such adult
1502 psychiatric beds. This written agreement by the recipient of the
1503 certificate of need shall be fully binding on any subsequent owner
1504 of the hospital if the ownership of the hospital is transferred at
1505 any time after the issuance of the certificate of need. Agreement
1506 that the adult psychiatric beds will not be certified for
1507 participation in the Medicaid program shall be a condition of the
1508 issuance of a certificate of need to any person under this
1509 subparagraph (a)(v), and if such hospital at any time after the
1510 issuance of the certificate of need, regardless of the ownership
1511 of the hospital, has any of such adult psychiatric beds certified
1512 for participation in the Medicaid program or admits or keeps any
1513 Medicaid patients in such adult psychiatric beds, the State
1514 Department of Health shall revoke the certificate of need, if it
1515 is still outstanding, and shall deny or revoke the license of the
1516 hospital at the time that the department determines, after a
1517 hearing complying with due process, that the hospital has failed
1518 to comply with any of the conditions upon which the certificate of
1519 need was issued, as provided in this subparagraph and in the
1520 written agreement by the recipient of the certificate of need.
1521 <u>(vi) The department may issue a certificate or</u>
1522 <u>certificates of need for the expansion of child psychiatric beds</u>
1523 <u>or the conversion of other beds to child psychiatric beds at the</u>
1524 <u>University of Mississippi Medical Center. For purposes of this</u>
1525 <u>subparagraph (a)(vi), the provision of Section 41-7-193(1)</u>
1526 <u>requiring substantial compliance with the projection of need as</u>

1527 reported in the current State Health Plan is waived. The total
1528 number of beds that may be authorized under the authority of this
1529 subparagraph (a)(vi) shall not exceed fifteen (15) beds. There
1530 shall be no prohibition or restrictions on participation in the
1531 Medicaid program (Section 43-13-101 et seq.) for the hospital
1532 receiving the certificate of need authorized under this
1533 subparagraph (a)(vi) or for the beds converted pursuant to the
1534 authority of that certificate of need.
1535 (b) From and after July 1, 1990, no hospital,
1536 psychiatric hospital or chemical dependency hospital shall be
1537 authorized to add any child/adolescent psychiatric or
1538 child/adolescent chemical dependency beds or convert any beds of
1539 another category to child/adolescent psychiatric or
1540 child/adolescent chemical dependency beds without a certificate of
1541 need under the authority of subsection (1)(c) of this section.
1542 (5) The department may issue a certificate of need to a
1543 county hospital in Winston County for the conversion of fifteen
1544 (15) acute care beds to geriatric psychiatric care beds.
1545 (6) The State Department of Health shall issue a certificate
1546 of need to a Mississippi corporation qualified to manage a
1547 long-term care hospital as defined in Section 41-7-173(h)(xii) in
1548 Harrison County, not to exceed eighty (80) beds, including any
1549 necessary renovation or construction required for licensure and
1550 certification, provided that the recipient of the certificate of
1551 need agrees in writing that the long-term care hospital will not
1552 at any time participate in the Medicaid program (Section 43-13-101
1553 et seq.) or admit or keep any patients in the long-term care
1554 hospital who are participating in the Medicaid program. This
1555 written agreement by the recipient of the certificate of need
1556 shall be fully binding on any subsequent owner of the long-term
1557 care hospital, if the ownership of the facility is transferred at
1558 any time after the issuance of the certificate of need. Agreement
1559 that the long-term care hospital will not participate in the
1560 Medicaid program shall be a condition of the issuance of a

1561 certificate of need to any person under this subsection (6), and
1562 if such long-term care hospital at any time after the issuance of
1563 the certificate of need, regardless of the ownership of the
1564 facility, participates in the Medicaid program or admits or keeps
1565 any patients in the facility who are participating in the Medicaid
1566 program, the State Department of Health shall revoke the
1567 certificate of need, if it is still outstanding, and shall deny or
1568 revoke the license of the long-term care hospital, at the time
1569 that the department determines, after a hearing complying with due
1570 process, that the facility has failed to comply with any of the
1571 conditions upon which the certificate of need was issued, as
1572 provided in this subsection and in the written agreement by the
1573 recipient of the certificate of need. For purposes of this
1574 subsection, the provision of Section 41-7-193(1) requiring
1575 substantial compliance with the projection of need as reported in
1576 the current State Health Plan is hereby waived.
1577 (7) The State Department of Health may issue a certificate
1578 of need to any hospital in the state to utilize a portion of its
1579 beds for the "swing-bed" concept. Any such hospital must be in
1580 conformance with the federal regulations regarding such swing-bed
1581 concept at the time it submits its application for a certificate
1582 of need to the State Department of Health, except that such
1583 hospital may have more licensed beds or a higher average daily
1584 census (ADC) than the maximum number specified in federal
1585 regulations for participation in the swing-bed program. Any
1586 hospital meeting all federal requirements for participation in the
1587 swing-bed program which receives such certificate of need shall
1588 render services provided under the swing-bed concept to any
1589 patient eligible for Medicare (Title XVIII of the Social Security
1590 Act) who is certified by a physician to be in need of such
1591 services, and no such hospital shall permit any patient who is
1592 eligible for both Medicaid and Medicare or eligible only for
1593 Medicaid to stay in the swing beds of the hospital for more than
1594 thirty (30) days per admission unless the hospital receives prior

1595 approval for such patient from the Division of Medicaid, Office of
1596 the Governor. Any hospital having more licensed beds or a higher
1597 average daily census (ADC) than the maximum number specified in
1598 federal regulations for participation in the swing-bed program
1599 which receives such certificate of need shall develop a procedure
1600 to insure that before a patient is allowed to stay in the swing
1601 beds of the hospital, there are no vacant nursing home beds
1602 available for that patient located within a fifty-mile radius of
1603 the hospital. When any such hospital has a patient staying in the
1604 swing beds of the hospital and the hospital receives notice from a
1605 nursing home located within such radius that there is a vacant bed
1606 available for that patient, the hospital shall transfer the
1607 patient to the nursing home within a reasonable time after receipt
1608 of the notice. Any hospital which is subject to the requirements
1609 of the two (2) preceding sentences of this subsection may be
1610 suspended from participation in the swing-bed program for a
1611 reasonable period of time by the State Department of Health if the
1612 department, after a hearing complying with due process, determines
1613 that the hospital has failed to comply with any of those
1614 requirements.

1615 (8) The Department of Health shall not grant approval for or
1616 issue a certificate of need to any person proposing the new
1617 construction of, addition to or expansion of a health care
1618 facility as defined in subparagraph (viii) of Section 41-7-173(h).

1619 (9) The Department of Health shall not grant approval for or
1620 issue a certificate of need to any person proposing the
1621 establishment of, or expansion of the currently approved territory
1622 of, or the contracting to establish a home office, subunit or
1623 branch office within the space operated as a health care facility
1624 as defined in Section 41-7-173(h)(i) through (viii) by a health
1625 care facility as defined in subparagraph (ix) of Section
1626 41-7-173(h).

1627 (10) Health care facilities owned and/or operated by the
1628 state or its agencies are exempt from the restraints in this

1629 section against issuance of a certificate of need if such addition
1630 or expansion consists of repairing or renovation necessary to
1631 comply with the state licensure law. This exception shall not
1632 apply to the new construction of any building by such state
1633 facility. This exception shall not apply to any health care
1634 facilities owned and/or operated by counties, municipalities,
1635 districts, unincorporated areas, other defined persons, or any
1636 combination thereof.
1637 (11) The new construction, renovation or expansion of or
1638 addition to any health care facility defined in subparagraph (ii)
1639 (psychiatric hospital), subparagraph (iv) (skilled nursing
1640 facility), subparagraph (vi) (intermediate care facility),
1641 subparagraph (viii) (intermediate care facility for the mentally
1642 retarded) and subparagraph (x) (psychiatric residential treatment
1643 facility) of Section 41-7-173(h) which is owned by the State of
1644 Mississippi and under the direction and control of the State
1645 Department of Mental Health, and the addition of new beds or the
1646 conversion of beds from one category to another in any such
1647 defined health care facility which is owned by the State of
1648 Mississippi and under the direction and control of the State
1649 Department of Mental Health, shall not require the issuance of a
1650 certificate of need under Section 41-7-171 et seq.,
1651 notwithstanding any provision in Section 41-7-171 et seq. to the
1652 contrary.
1653 (12) The new construction, renovation or expansion of or
1654 addition to any veterans homes or domiciliaries for eligible
1655 veterans of the State of Mississippi as authorized under Section
1656 35-1-19 shall not require the issuance of a certificate of need,
1657 notwithstanding any provision in Section 41-7-171 et seq. to the
1658 contrary.
1659 (13) The new construction of a nursing facility or nursing
1660 facility beds or the conversion of other beds to nursing facility
1661 beds shall not require the issuance of a certificate of need,
1662 notwithstanding any provision in Section 41-7-171 et seq. to the

1663 contrary, if the conditions of this subsection are met.

1664 (a) Before any construction or conversion may be
1665 undertaken without a certificate of need, the owner of the nursing
1666 facility, in the case of an existing facility, or the applicant to
1667 construct a nursing facility, in the case of new construction,
1668 first must file a written notice of intent and sign a written
1669 agreement with the State Department of Health that the entire
1670 nursing facility will not at any time participate in or have any
1671 beds certified for participation in the Medicaid program (Section
1672 43-13-101 et seq.), will not admit or keep any patients in the
1673 nursing facility who are participating in the Medicaid program,
1674 and will not submit any claim for Medicaid reimbursement for any
1675 patient in the facility. This written agreement by the owner or
1676 applicant shall be a condition of exercising the authority under
1677 this subsection without a certificate of need, and the agreement
1678 shall be fully binding on any subsequent owner of the nursing
1679 facility if the ownership of the facility is transferred at any
1680 time after the agreement is signed. After the written agreement
1681 is signed, the Division of Medicaid and the State Department of
1682 Health shall not certify any beds in the nursing facility for
1683 participation in the Medicaid program. If the nursing facility
1684 violates the terms of the written agreement by participating in
1685 the Medicaid program, having any beds certified for participation
1686 in the Medicaid program, admitting or keeping any patient in the
1687 facility who is participating in the Medicaid program, or
1688 submitting any claim for Medicaid reimbursement for any patient in
1689 the facility, the State Department of Health shall revoke the
1690 license of the nursing facility at the time that the department
1691 determines, after a hearing complying with due process, that the
1692 facility has violated the terms of the written agreement.

1693 (b) For the purposes of this subsection, participation
1694 in the Medicaid program by a nursing facility includes Medicaid
1695 reimbursement of coinsurance and deductibles for recipients who
1696 are qualified Medicare beneficiaries and/or those who are dually

1697 eligible. Any nursing facility exercising the authority under
1698 this subsection may not bill or submit a claim to the Division of
1699 Medicaid for services to qualified Medicare beneficiaries and/or
1700 those who are dually eligible.

1701 (c) The new construction of a nursing facility or
1702 nursing facility beds or the conversion of other beds to nursing
1703 facility beds described in this section must be either a part of a
1704 completely new continuing care retirement community, as described
1705 in the latest edition of the Mississippi State Health Plan, or an
1706 addition to existing personal care and independent living
1707 components, and so that the completed project will be a continuing
1708 care retirement community, containing (i) independent living
1709 accommodations, (ii) personal care beds, and (iii) the nursing
1710 home facility beds. The three (3) components must be located on a
1711 single site and be operated as one (1) inseparable facility. The
1712 nursing facility component must contain a minimum of thirty (30)
1713 beds. Any nursing facility beds authorized by this section will
1714 not be counted against the bed need set forth in the State Health
1715 Plan, as identified in Section 41-7-171, et seq.

1716 This subsection (13) shall stand repealed from and after July
1717 1, 2001.

1718 (14) The State Department of Health shall issue a
1719 certificate of need to any hospital which is currently licensed
1720 for two hundred fifty (250) or more acute care beds and is located
1721 in any general hospital service area not having a comprehensive
1722 cancer center, for the establishment and equipping of such a
1723 center which provides facilities and services for outpatient
1724 radiation oncology therapy, outpatient medical oncology therapy,
1725 and appropriate support services including the provision of
1726 radiation therapy services. The provision of Section 41-7-193(1)
1727 regarding substantial compliance with the projection of need as
1728 reported in the current State Health Plan is waived for the
1729 purpose of this subsection.

1730 (15) Nothing in this section or in any other provision of

1731 Section 41-7-171 et seq. shall prevent any nursing facility from

1732 designating an appropriate number of existing beds in the facility

1733 as beds for providing care exclusively to patients with

1734 Alzheimer's disease.

1735 SECTION 3. Section 1 of this act shall take effect and be in

1736 force from and after June 30, 1999, and Section 2 of this act

1737 shall take effect and be in force from and after July 1, 1999.