REPORT OF CONFERENCE COMMITTEE

MR. PRESIDENT AND MR. SPEAKER:

We, the undersigned conferees, have had under consideration the amendments to the following entitled BILL:

S.B. No. 2679: Nursing facilities; require preadmission screening and authorize additional beds.

We, therefore, respectfully submit the following report and recommendation:

1. **That the House recede from its Amendment No. 1.**

2. **That the Senate and House adopt the following amendment:**

Amend by striking all after the enacting clause and inserting in lieu thereof the following:

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

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

(1) Inpatient hospital services.

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

(b) From and after July 1, 1994, the Executive Director of the Division of Medicaid shall amend the Mississippi Title XIX Inpatient Hospital Reimbursement Plan to remove the occupancy rate penalty from the calculation of the Medicaid Capital Cost

Component utilized to determine total hospital costs allocated to the Medicaid Program.

(2) Outpatient hospital services. Provided that where the same services are reimbursed as clinic services, the division may revise the rate or methodology of outpatient reimbursement to maintain consistency, efficiency, economy and quality of care.

(3) Laboratory and x-ray services.

(4) Nursing facility services.

(a) The division shall make full payment to nursing facilities for each day, not exceeding fifty-two (52) days per year, that a patient is absent from the facility on home leave. However, before payment may be made for more than eighteen (18) home leave days in a year for a patient, the patient must have written authorization from a physician stating that the patient is physically and mentally able to be away from the facility on home leave. Such authorization must be filed with the division before it will be effective and the authorization shall be effective for three (3) months from the date it is received by the division, unless it is revoked earlier by the physician because of a change in the condition of the patient.

(b) From and after July 1, 1993, the division shall implement the integrated case-mix payment and quality monitoring system developed pursuant to Section 43-13-122, which includes the fair rental system for property costs and in which recapture of depreciation is eliminated. The division may revise the reimbursement methodology for the case-mix payment system by reducing payment for hospital leave and therapeutic home leave days to the lowest case-mix category for nursing facilities, modifying the current method of scoring residents so that only services provided at the nursing facility are considered in calculating a facility's per diem, and the division may limit administrative and operating costs, but in no case shall these costs be less than one hundred nine percent (109%) of the median administrative and operating costs for each class of facility, not to exceed the median used to calculate the nursing facility

reimbursement for Fiscal Year 1996, to be applied uniformly to all long-term care facilities. This paragraph (b) shall stand repealed on July 1, 1997.

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

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

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

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

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

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

(A) In each of the areas of expertise defined under subparagraphs (i)(A) and (i)(B), the Executive Director of the Division of Medicaid shall appoint one (1) person chosen from the private sector nursing home industry in the state, which may include independent accountants and consultants serving the industry;

(B) In each of the areas of expertise defined under subparagraphs (i)(A) and (i)(B), the Executive Director of the Division of Medicaid shall appoint one (1) person who is

employed by the state who does not participate directly in desk reviews or audits of nursing facilities in the two (2) areas of review;

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

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

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

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

(v) Proceedings of the Review Board shall be of record.

(vi) Appeals to the Review Board shall be in writing and shall set out the issues, a statement of alleged facts and reasons supporting the provider's position. Relevant documents may also be attached. The appeal shall be filed within thirty (30) days from the date the provider is notified of the

action being appealed or, if informal review procedures are taken, as provided by administrative regulations of the Division of Medicaid, within thirty (30) days after a decision has been rendered through informal hearing procedures.

(vii) The provider shall be notified of the hearing date by certified mail within thirty (30) days from the date the Division of Medicaid receives the request for appeal. Notification of the hearing date shall in no event be less than thirty (30) days before the scheduled hearing date. The appeal may be heard on shorter notice by written agreement between the provider and the Division of Medicaid.

(viii) Within thirty (30) days from the date of the hearing, the Review Board panel shall render a written recommendation to the Executive Director of the Division of Medicaid setting forth the issues, findings of fact and applicable law, regulations or provisions.

(ix) The Executive Director of the Division of Medicaid shall, upon review of the recommendation, the proceedings and the record, prepare a written decision which shall be mailed to the nursing facility provider no later than twenty (20) days after the submission of the recommendation by the panel. The decision of the executive director is final, subject only to judicial review.

(x) Appeals from a final decision shall be made to the Chancery Court of Hinds County. The appeal shall be filed with the court within thirty (30) days from the date the decision of the Executive Director of the Division of Medicaid becomes final.

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

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

of Medicaid.

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

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

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

(iii) Explain that such plan and services are available only if the applicant or the applicant's legal representative chooses a home- or community-based alternative to

nursing facility care, and that the applicant is free to choose nursing facility care.

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

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

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

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

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

(f) When a facility of a category that does not require a certificate of need for construction and that could not be eligible for Medicaid reimbursement is constructed to nursing facility specifications for licensure and certification, and the facility is subsequently converted to a nursing facility pursuant to a certificate of need that authorizes conversion only and the applicant for the certificate of need was assessed an application review fee based on capital expenditures incurred in constructing the facility, the division shall allow reimbursement for capital expenditures necessary for construction of the facility that were incurred within the twenty-four (24) consecutive calendar months immediately preceding the date that the certificate of need authorizing such conversion was issued, to the same extent that

reimbursement would be allowed for construction of a new nursing facility pursuant to a certificate of need that authorizes such construction. The reimbursement authorized in this subparagraph (f) may be made only to facilities the construction of which was completed after June 30, 1989. Before the division shall be authorized to make the reimbursement authorized in this subparagraph (f), the division first must have received approval from the Health Care Financing Administration of the United States Department of Health and Human Services of the change in the state Medicaid plan providing for such reimbursement.

(5) Periodic screening and diagnostic services for individuals under age twenty-one (21) years as are needed to identify physical and mental defects and to provide health care treatment and other measures designed to correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services regardless of whether these services are included in the state plan. The division may include in its periodic screening and diagnostic program those discretionary services authorized under the federal regulations adopted to implement Title XIX of the federal Social Security Act, as amended. The division, in obtaining physical therapy services, occupational therapy services, and services for individuals with speech, hearing and language disorders, may enter into a cooperative agreement with the State Department of Education for the provision of such services to handicapped students by public school districts using state funds which are provided from the appropriation to the Department of Education to obtain federal matching funds through the division. The division, in obtaining medical and psychological evaluations for children in the custody of the State Department of Human Services may enter into a cooperative agreement with the State Department of Human Services for the provision of such services using state funds which are provided from the appropriation to the Department of Human Services to obtain federal matching funds through the division.

On July 1, 1993, all fees for periodic screening and

diagnostic services under this paragraph (5) shall be increased by twenty-five percent (25%) of the reimbursement rate in effect on June 30, 1993.

(6) Physicians' services. On January 1, 1996, all fees for physicians' services shall be reimbursed at seventy percent (70%) of the rate established on January 1, 1994, under Medicare (Title XVIII of the Social Security Act), as amended, and the division may adjust the physicians' reimbursement schedule to reflect the differences in relative value between Medicaid and Medicare.

(7) (a) Home health services for eligible persons, not to exceed in cost the prevailing cost of nursing facility services, not to exceed sixty (60) visits per year.

(b) The division may revise reimbursement for home health services in order to establish equity between reimbursement for home health services and reimbursement for institutional services within the Medicaid program. This paragraph (b) shall stand repealed on July 1, 1997.

(8) Emergency medical transportation services. On January 1, 1994, emergency medical transportation services shall be reimbursed at seventy percent (70%) of the rate established under Medicare (Title XVIII of the Social Security Act), as amended. "Emergency medical transportation services" shall mean, but shall not be limited to, the following services by a properly permitted ambulance operated by a properly licensed provider in accordance with the Emergency Medical Services Act of 1974 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids, (vi) disposable supplies, (vii) similar services.

(9) Legend and other drugs as may be determined by the division. The division may implement a program of prior approval for drugs to the extent permitted by law. Payment by the division for covered multiple source drugs shall be limited to the lower of the upper limits established and published by the Health Care Financing Administration (HCFA) plus a dispensing fee of Four Dollars and Ninety-one Cents ($4.91), or the estimated acquisition

cost (EAC) as determined by the division plus a dispensing fee of Four Dollars and Ninety-one Cents ($4.91), or the providers' usual and customary charge to the general public. The division shall allow five (5) prescriptions per month for noninstitutionalized Medicaid recipients; however, exceptions for up to ten (10) prescriptions per month shall be allowed, with the approval of the director.

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

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

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

As used in this paragraph (9), "estimated acquisition cost" means the division's best estimate of what price providers generally are paying for a drug in the package size that providers buy most frequently. Product selection shall be made in compliance with existing state law; however, the division may reimburse as if the prescription had been filled under the generic name. The division may provide otherwise in the case of specified drugs when the consensus of competent medical advice is that trademarked drugs are substantially more effective.

(10) Dental care that is an adjunct to treatment of an acute medical or surgical condition; services of oral surgeons and dentists in connection with surgery related to the jaw or any structure contiguous to the jaw or the reduction of any fracture of the jaw or any facial bone; and emergency dental extractions

and treatment related thereto. On January 1, 1994, all fees for dental care and surgery under authority of this paragraph (10) shall be increased by twenty percent (20%) of the reimbursement rate as provided in the Dental Services Provider Manual in effect on December 31, 1993.

(11) Eyeglasses necessitated by reason of eye surgery, and as prescribed by a physician skilled in diseases of the eye or an optometrist, whichever the patient may select.

(12) Intermediate care facility services.

(a) The division shall make full payment to all intermediate care facilities for the mentally retarded for each day, not exceeding eighty-four (84) days per year, that a patient is absent from the facility on home leave. Payment may be made for the following home leave days in addition to the eighty-four-day limitation: Christmas, the day before Christmas, the day after Christmas, Thanksgiving, the day before Thanksgiving and the day after Thanksgiving. However, before payment may be made for more than eighteen (18) home leave days in a year for a patient, the patient must have written authorization from a physician stating that the patient is physically and mentally able to be away from the facility on home leave. Such authorization must be filed with the division before it will be effective, and the authorization shall be effective for three (3) months from the date it is received by the division, unless it is revoked earlier by the physician because of a change in the condition of the patient.

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

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

(14) Clinic services. Such diagnostic, preventive, therapeutic, rehabilitative or palliative services furnished to an outpatient by or under the supervision of a physician or dentist

in a facility which is not a part of a hospital but which is organized and operated to provide medical care to outpatients. Clinic services shall include any services reimbursed as outpatient hospital services which may be rendered in such a facility, including those that become so after July 1, 1991. On January 1, 1994, all fees for physicians' services reimbursed under authority of this paragraph (14) shall be reimbursed at seventy percent (70%) of the rate established on January 1, 1993, under Medicare (Title XVIII of the Social Security Act), as amended, or the amount that would have been paid under the division's fee schedule that was in effect on December 31, 1993, whichever is greater, and the division may adjust the physicians' reimbursement schedule to reflect the differences in relative value between Medicaid and Medicare. However, on January 1, 1994, the division may increase any fee for physicians' services in the division's fee schedule on December 31, 1993, that was greater than seventy percent (70%) of the rate established under Medicare by no more than ten percent (10%). On January 1, 1994, all fees for dentists' services reimbursed under authority of this paragraph (14) shall be increased by twenty percent (20%) of the reimbursement rate as provided in the Dental Services Provider Manual in effect on December 31, 1993.

(15) Home- and community-based services, as provided under Title XIX of the federal Social Security Act, as amended, under waivers, subject to the availability of funds specifically appropriated therefor by the Legislature. Payment for such services shall be limited to individuals who would be eligible for and would otherwise require the level of care provided in a nursing facility. <u>The home- and community-based services authorized under this paragraph shall be expanded over a five-year period beginning July 1, 1999.</u> The division shall certify case management agencies to provide case management services and provide for home- and community-based services for eligible individuals under this paragraph. The home- and community-based services under this paragraph and the activities performed by

certified case management agencies under this paragraph shall be funded using state funds that are provided from the appropriation to the Division of Medicaid and used to match federal funds * * *.

(16) Mental health services. Approved therapeutic and case management services provided by (a) an approved regional mental health/retardation center established under Sections 41-19-31 through 41-19-39, or by another community mental health service provider meeting the requirements of the Department of Mental Health to be an approved mental health/retardation center if determined necessary by the Department of Mental Health, using state funds which are provided from the appropriation to the State Department of Mental Health and used to match federal funds under a cooperative agreement between the division and the department, or (b) a facility which is certified by the State Department of Mental Health to provide therapeutic and case management services, to be reimbursed on a fee for service basis. Any such services provided by a facility described in paragraph (b) must have the prior approval of the division to be reimbursable under this section. After June 30, 1997, mental health services provided by regional mental health/retardation centers established under Sections 41-19-31 through 41-19-39, or by hospitals as defined in Section 41-9-3(a) and/or their subsidiaries and divisions, or by psychiatric residential treatment facilities as defined in Section 43-11-1, or by another community mental health service provider meeting the requirements of the Department of Mental Health to be an approved mental health/retardation center if determined necessary by the Department of Mental Health, shall not be included in or provided under any capitated managed care pilot program provided for under paragraph (24) of this section.

(17) Durable medical equipment services and medical supplies restricted to patients receiving home health services unless waived on an individual basis by the division. The division shall not expend more than Three Hundred Thousand Dollars ($300,000.00) of state funds annually to pay for medical supplies authorized under this paragraph.

(18) Notwithstanding any other provision of this section to the contrary, the division shall make additional reimbursement to hospitals which serve a disproportionate share of low-income patients and which meet the federal requirements for such payments as provided in Section 1923 of the federal Social Security Act and any applicable regulations.

(19) (a) Perinatal risk management services. The division shall promulgate regulations to be effective from and after October 1, 1988, to establish a comprehensive perinatal system for risk assessment of all pregnant and infant Medicaid recipients and for management, education and follow-up for those who are determined to be at risk. Services to be performed include case management, nutrition assessment/counseling, psychosocial assessment/counseling and health education. The division shall set reimbursement rates for providers in conjunction with the State Department of Health.

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

(20) Home- and community-based services for physically disabled approved services as allowed by a waiver from the United States Department of Health and Human Services for home- and community-based services for physically disabled people using

state funds which are provided from the appropriation to the State Department of Rehabilitation Services and used to match federal funds under a cooperative agreement between the division and the department, provided that funds for these services are specifically appropriated to the Department of Rehabilitation Services.

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

(22) Ambulatory services delivered in federally qualified health centers and in clinics of the local health departments of the State Department of Health for individuals eligible for medical assistance under this article based on reasonable costs as determined by the division.

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

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

(25) Birthing center services.

(26) Hospice care. As used in this paragraph, the term "hospice care" means a coordinated program of active professional medical attention within the home and outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses which are experienced during the final stages of illness and during dying and bereavement and meets the Medicare requirements for participation as a hospice as provided in 42 CFR Part 418.

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

(28) Other health insurance premiums which are cost effective as defined by the Secretary of Health and Human Services. Medicare eligible must have Medicare Part B before other insurance premiums can be paid.

(29) The Division of Medicaid may apply for a waiver from the Department of Health and Human Services for home- and community-based services for developmentally disabled people using state funds which are provided from the appropriation to the State Department of Mental Health and used to match federal funds under

a cooperative agreement between the division and the department, provided that funds for these services are specifically appropriated to the Department of Mental Health.

(30) Pediatric skilled nursing services for eligible persons under twenty-one (21) years of age.

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

(32) Care and services provided in Christian Science Sanatoria operated by or listed and certified by The First Church of Christ Scientist, Boston, Massachusetts, rendered in connection with treatment by prayer or spiritual means to the extent that such services are subject to reimbursement under Section 1903 of the Social Security Act.

(33) Podiatrist services.

(34) Personal care services provided in a pilot program to not more than forty (40) residents at a location or locations to be determined by the division and delivered by individuals qualified to provide such services, as allowed by waivers under Title XIX of the Social Security Act, as amended. The division shall not expend more than Three Hundred Thousand Dollars ($300,000.00) annually to provide such personal care services. The division shall develop recommendations for the effective regulation of any facilities that would provide personal care services which may become eligible for Medicaid reimbursement under this section, and shall present such recommendations with any proposed legislation to the 1996 Regular Session of the Legislature on or before January 1, 1996.

(35) Services and activities authorized in Sections 43-27-101 and 43-27-103, using state funds that are provided from the appropriation to the State Department of Human Services and used to match federal funds under a cooperative agreement between

the division and the department.

(36) Nonemergency transportation services for Medicaid-eligible persons, to be provided by the Department of Human Services. The division may contract with additional entities to administer nonemergency transportation services as it deems necessary. All providers shall have a valid driver's license, vehicle inspection sticker and a standard liability insurance policy covering the vehicle.

(37) Targeted case management services for individuals with chronic diseases, with expanded eligibility to cover services to uninsured recipients, on a pilot program basis. This paragraph (37) shall be contingent upon continued receipt of special funds from the Health Care Financing Authority and private foundations who have granted funds for planning these services. No funding for these services shall be provided from State General Funds.

(38) Chiropractic services: a chiropractor's manual manipulation of the spine to correct a subluxation, if x-ray demonstrates that a subluxation exists and if the subluxation has resulted in a neuromusculoskeletal condition for which manipulation is appropriate treatment. Reimbursement for chiropractic services shall not exceed Seven Hundred Dollars ($700.00) per year per recipient.

Notwithstanding any provision of this article, except as authorized in the following paragraph and in Section 43-13-139, neither (a) the limitations on quantity or frequency of use of or the fees or charges for any of the care or services available to recipients under this section, nor (b) the payments or rates of reimbursement to providers rendering care or services authorized under this section to recipients, may be increased, decreased or otherwise changed from the levels in effect on July 1, 1986, unless such is authorized by an amendment to this section by the Legislature. However, the restriction in this paragraph shall not prevent the division from changing the payments or rates of reimbursement to providers without an amendment to this section whenever such changes are required by federal law or regulation,

or whenever such changes are necessary to correct administrative errors or omissions in calculating such payments or rates of reimbursement.

Notwithstanding any provision of this article, no new groups or categories of recipients and new types of care and services may be added without enabling legislation from the Mississippi Legislature, except that the division may authorize such changes without enabling legislation when such addition of recipients or services is ordered by a court of proper authority. The director shall keep the Governor advised on a timely basis of the funds available for expenditure and the projected expenditures. In the event current or projected expenditures can be reasonably anticipated to exceed the amounts appropriated for any fiscal year, the Governor, after consultation with the director, shall discontinue any or all of the payment of the types of care and services as provided herein which are deemed to be optional services under Title XIX of the federal Social Security Act, as amended, for any period necessary to not exceed appropriated funds, and when necessary shall institute any other cost containment measures on any program or programs authorized under the article to the extent allowed under the federal law governing such program or programs, it being the intent of the Legislature that expenditures during any fiscal year shall not exceed the amounts appropriated for such fiscal year.

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

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

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

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

(c) A change over a period of two (2) years' time, as

established by the State Department of Health, in existing bed complement through the addition of more than ten (10) beds or more than ten percent (10%) of the total bed capacity of a designated licensed category or subcategory of any health care facility, whichever is less, from one physical facility or site to another; the conversion over a period of two (2) years' time, as established by the State Department of Health, of existing bed complement of more than ten (10) beds or more than ten percent (10%) of the total bed capacity of a designated licensed category or subcategory of any such health care facility, whichever is less; or the alteration, modernizing or refurbishing of any unit or department wherein such beds may be located; provided, however, that from and after July 1, 1994, no health care facility shall be authorized to add any beds or convert any beds to another category of beds without a certificate of need under the authority of subsection (1)(c) of this section unless there is a projected need for such beds in the planning district in which the facility is located, as reported in the most current State Health Plan;

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

(i) Open heart surgery services;

(ii) Cardiac catheterization services;

(iii) Comprehensive inpatient rehabilitation services;

(iv) Licensed psychiatric services;

(v) Licensed chemical dependency services;

(vi) Radiation therapy services;

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

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

(ix) Home health services;

(x) Swing-bed services;

(xi) Ambulatory surgical services;

(xii) Magnetic resonance imaging services;

(xiii) Extracorporeal shock wave lithotripsy services;

(xiv) Long-term care hospital services;

(xv) Positron Emission Tomography (PET) Services;

(e) The relocation of one or more health services from one physical facility or site to another physical facility or site, unless such relocation, which does not involve a capital expenditure by or on behalf of a health care facility, is the result of an order of a court of appropriate jurisdiction or a result of pending litigation in such court, or by order of the State Department of Health, or by order of any other agency or legal entity of the state, the federal government, or any political subdivision of either, whose order is also approved by the State Department of Health;

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

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

(h) The change of ownership of any health care facility defined in subparagraphs (iv), (vi) and (viii) of Section 41-7-173(h), in which a notice of intent as described in paragraph (g) has not been filed and if the Executive Director, Division of Medicaid, Office of the Governor, has not certified in writing

that there will be no increase in allowable costs to Medicaid from revaluation of the assets or from increased interest and depreciation as a result of the proposed change of ownership;

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

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

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

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

* * *

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

* * *

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

* * *

(c) The department may issue a certificate of need for the addition to or expansion of any skilled nursing facility that is part of an existing continuing care retirement community located in Madison County, provided that the recipient of the certificate of need agrees in writing that the skilled nursing facility will not at any time participate in the Medicaid program (Section 43-13-101 et seq.) or admit or keep any patients in the skilled nursing facility who are participating in the Medicaid program. This written agreement by the recipient of the certificate of need shall be fully binding on any subsequent owner of the skilled nursing facility, if the ownership of the facility is transferred at any time after the issuance of the certificate of need. Agreement that the skilled nursing facility will not participate in the Medicaid program shall be a condition of the issuance of a certificate of need to any person under this paragraph (c), and if such skilled nursing facility at any time after the issuance of the certificate of need, regardless of the ownership of the facility, participates in the Medicaid program or admits or keeps any patients in the facility who are participating in the Medicaid program, the State Department of Health shall revoke the certificate of need, if it is still outstanding, and shall deny or revoke the license of the skilled nursing facility, at the time that the department determines, after a hearing complying with due process, that the facility has failed to comply with any of the conditions upon which the certificate of need was issued, as provided in this paragraph and in the written agreement by the recipient of the certificate of need. The total number of

beds that may be authorized under the authority of this paragraph (c) shall not exceed sixty (60) beds.

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

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

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

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

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

(i) The department may issue a certificate of need for the new construction of a skilled nursing facility in Leake County, provided that the recipient of the certificate of need agrees in writing that the skilled nursing facility will not at any time participate in the Medicaid program (Section 43-13-101 et seq.) or admit or keep any patients in the skilled nursing facility who are participating in the Medicaid program. This written agreement by the recipient of the certificate of need shall be fully binding on any subsequent owner of the skilled nursing facility, if the ownership of the facility is transferred at any time after the issuance of the certificate of need. Agreement that the skilled nursing facility will not participate in the Medicaid program shall be a condition of the issuance of a certificate of need to any person under this paragraph (i), and if such skilled nursing facility at any time after the issuance of the certificate of need, regardless of the ownership of the facility, participates in the Medicaid program or admits or keeps any patients in the facility who are participating in the Medicaid program, the State Department of Health shall revoke the certificate of need, if it is still outstanding, and shall deny or revoke the license of the skilled nursing facility, at the time that the department determines, after a hearing complying with due process, that the facility has failed to comply with any of the conditions upon which the certificate of need was issued, as provided in this paragraph and in the written agreement by the recipient of the certificate of need. The provision of Section 43-7-193(1) regarding substantial compliance of the projection of

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

* * *

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

(k) The department may issue a certificate of need for the construction of a nursing facility at a continuing care retirement community in Lowndes County, provided that the recipient of the certificate of need agrees in writing that the nursing facility will not at any time participate in the Medicaid program (Section 43-13-101 et seq.) or admit or keep any patients in the nursing facility who are participating in the Medicaid program. This written agreement by the recipient of the certificate of need shall be fully binding on any subsequent owner of the nursing facility, if the ownership of the facility is transferred at any time after the issuance of the certificate of

need. Agreement that the nursing facility will not participate in the Medicaid program shall be a condition of the issuance of a certificate of need to any person under this paragraph (k), and if such nursing facility at any time after the issuance of the certificate of need, regardless of the ownership of the facility, participates in the Medicaid program or admits or keeps any patients in the facility who are participating in the Medicaid program, the State Department of Health shall revoke the certificate of need, if it is still outstanding, and shall deny or revoke the license of the nursing facility, at the time that the department determines, after a hearing complying with due process, that the facility has failed to comply with any of the conditions upon which the certificate of need was issued, as provided in this paragraph and in the written agreement by the recipient of the certificate of need. The total number of beds that may be authorized under the authority of this paragraph (k) shall not exceed sixty (60) beds.

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

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

Medicaid reimbursement in the nursing facility in any day or for any patient in the nursing facility. This written agreement by the recipient of the certificate of need shall be a condition of the issuance of the certificate of need under this paragraph, and the agreement shall be fully binding on any subsequent owner of the nursing facility if the ownership of the nursing facility is transferred at any time after the issuance of the certificate of need. After this written agreement is executed, the Division of Medicaid and the State Department of Health shall not certify any of the beds in the nursing facility for participation in the Medicaid program. If the nursing facility violates the terms of the written agreement by admitting or keeping in the nursing facility on a regular or continuing basis any patients who are participating in the Medicaid program, the State Department of Health shall revoke the license of the nursing facility, at the time that the department determines, after a hearing complying with due process, that the nursing facility has violated the condition upon which the certificate of need was issued, as provided in this paragraph and in the written agreement. If the certificate of need authorized under this paragraph is not issued within twelve (12) months after July 1, 2001, the department shall deny the application for the certificate of need and shall not issue the certificate of need at any time after the twelve-month period, unless the issuance is contested. If the certificate of need is issued and substantial construction of the nursing facility beds has not commenced within eighteen (18) months after July 1, 2001, the State Department of Health, after a hearing complying with due process, shall revoke the certificate of need if it is still outstanding, and the department shall not issue a license for the nursing facility at any time after the eighteen-month period. Provided, however, that if the issuance of the certificate of need is contested, the department shall require substantial construction of the nursing facility beds within six (6) months after final adjudication on the issuance of the certificate of need.

(n) The department may issue a certificate of need for the new construction, addition or conversion of skilled nursing facility beds in Madison County, provided that the recipient of the certificate of need agrees in writing that the skilled nursing facility will not at any time participate in the Medicaid program (Section 43-13-101 et seq.) or admit or keep any patients in the skilled nursing facility who are participating in the Medicaid program. This written agreement by the recipient of the certificate of need shall be fully binding on any subsequent owner of the skilled nursing facility, if the ownership of the facility is transferred at any time after the issuance of the certificate of need. Agreement that the skilled nursing facility will not participate in the Medicaid program shall be a condition of the issuance of a certificate of need to any person under this paragraph (n), and if such skilled nursing facility at any time after the issuance of the certificate of need, regardless of the ownership of the facility, participates in the Medicaid program or admits or keeps any patients in the facility who are participating in the Medicaid program, the State Department of Health shall revoke the certificate of need, if it is still outstanding, and shall deny or revoke the license of the skilled nursing facility, at the time that the department determines, after a hearing complying with due process, that the facility has failed to comply with any of the conditions upon which the certificate of need was issued, as provided in this paragraph and in the written agreement by the recipient of the certificate of need. The total number of nursing facility beds that may be authorized by any certificate of need issued under this paragraph (n) shall not exceed sixty (60) beds. If the certificate of need authorized under this paragraph is not issued within twelve (12) months after July 1, 1998, the department shall deny the application for the certificate of need and shall not issue the certificate of need at any time after the twelve-month period, unless the issuance is contested. If the certificate of need is issued and substantial construction of the nursing facility beds has not commenced within eighteen (18)

months after the effective date of July 1, 1998, the State Department of Health, after a hearing complying with due process, shall revoke the certificate of need if it is still outstanding, and the department shall not issue a license for the nursing facility at any time after the eighteen-month period. Provided, however, that if the issuance of the certificate of need is contested, the department shall require substantial construction of the nursing facility beds within six (6) months after final adjudication on the issuance of the certificate of need.

(o) The department may issue a certificate of need for the new construction, addition or conversion of skilled nursing facility beds in Leake County, provided that the recipient of the certificate of need agrees in writing that the skilled nursing facility will not at any time participate in the Medicaid program (Section 43-13-101 et seq.) or admit or keep any patients in the skilled nursing facility who are participating in the Medicaid program. This written agreement by the recipient of the certificate of need shall be fully binding on any subsequent owner of the skilled nursing facility, if the ownership of the facility is transferred at any time after the issuance of the certificate of need. Agreement that the skilled nursing facility will not participate in the Medicaid program shall be a condition of the issuance of a certificate of need to any person under this paragraph (o), and if such skilled nursing facility at any time after the issuance of the certificate of need, regardless of the ownership of the facility, participates in the Medicaid program or admits or keeps any patients in the facility who are participating in the Medicaid program, the State Department of Health shall revoke the certificate of need, if it is still outstanding, and shall deny or revoke the license of the skilled nursing facility, at the time that the department determines, after a hearing complying with due process, that the facility has failed to comply with any of the conditions upon which the certificate of need was issued, as provided in this paragraph and in the written agreement by the recipient of the certificate of need. The total number of

nursing facility beds that may be authorized by any certificate of need issued under this paragraph (o) shall not exceed sixty (60) beds. If the certificate of need authorized under this paragraph is not issued within twelve (12) months after July 1, 2001, the department shall deny the application for the certificate of need and shall not issue the certificate of need at any time after the twelve-month period, unless the issuance is contested. If the certificate of need is issued and substantial construction of the nursing facility beds has not commenced within eighteen (18) months after the effective date of July 1, 2001, the State Department of Health, after a hearing complying with due process, shall revoke the certificate of need if it is still outstanding, and the department shall not issue a license for the nursing facility at any time after the eighteen-month period. Provided, however, that if the issuance of the certificate of need is contested, the department shall require substantial construction of the nursing facility beds within six (6) months after final adjudication on the issuance of the certificate of need.

(p) The department may issue a certificate of need for the construction of a municipally-owned nursing facility within the Town of Belmont in Tishomingo County, not to exceed sixty (60) beds, provided that the recipient of the certificate of need agrees in writing that the skilled nursing facility will not at any time participate in the Medicaid program (Section 43-13-101 et seq.) or admit or keep any patients in the skilled nursing facility who are participating in the Medicaid program. This written agreement by the recipient of the certificate of need shall be fully binding on any subsequent owner of the skilled nursing facility, if the ownership of the facility is transferred at any time after the issuance of the certificate of need. Agreement that the skilled nursing facility will not participate in the Medicaid program shall be a condition of the issuance of a certificate of need to any person under this paragraph (p), and if such skilled nursing facility at any time after the issuance of the certificate of need, regardless of the ownership of the

facility, participates in the Medicaid program or admits or keeps any patients in the facility who are participating in the Medicaid program, the State Department of Health shall revoke the certificate of need, if it is still outstanding, and shall deny or revoke the license of the skilled nursing facility, at the time that the department determines, after a hearing complying with due process, that the facility has failed to comply with any of the conditions upon which the certificate of need was issued, as provided in this paragraph and in the written agreement by the recipient of the certificate of need. The provision of Section 43-7-193(1) regarding substantial compliance of the projection of need as reported in the current State Health Plan is waived for the purposes of this paragraph. If the certificate of need authorized under this paragraph is not issued within twelve (12) months after July 1, 1998, the department shall deny the application for the certificate of need and shall not issue the certificate of need at any time after the twelve-month period, unless the issuance is contested. If the certificate of need is issued and substantial construction of the nursing facility beds has not commenced within eighteen (18) months after July 1, 1998, the State Department of Health, after a hearing complying with due process, shall revoke the certificate of need if it is still outstanding, and the department shall not issue a license for the nursing facility at any time after the eighteen-month period. Provided, however, that if the issuance of the certificate of need is contested, the department shall require substantial construction of the nursing facility beds within six (6) months after final adjudication on the issuance of the certificate of need.

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

in the fiscal year 1999 State Health Plan, in the manner provided in this paragraph (q). The total number of nursing facility beds that may be authorized by any certificate of need authorized under this paragraph (q) shall not exceed sixty (60) beds.

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

(iii) Subject to the provisions of subparagraph (v), the certificate of need issued under subparagraph (ii) for nursing facility beds in each Long-Term Care Planning District during each fiscal year shall first be available for nursing facility beds in the county in the district having the highest need for those beds, as shown in the fiscal year 1999 State Health Plan. If there are no applications for a certificate of need for nursing facility beds in the county having the highest need for

those beds by the date specified by the department, then the certificate of need shall be available for nursing facility beds in other counties in the district in descending order of the need for those beds, from the county with the second highest need to the county with the lowest need, until an application is received for nursing facility beds in an eligible county in the district.

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

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

any fiscal year of the four-year period, a certificate of need shall not be available again under this paragraph (q) for additional nursing facility beds in that county during the four-year period, and that county shall be excluded in determining which counties have the highest need for nursing facility beds in succeeding fiscal years.

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

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

(iii) The State Department of Health, in consultation with the Department of Mental Health and the Division of Medicaid, shall develop and prescribe the staffing levels, space requirements and other standards and requirements that must be met with regard to the nursing facility beds authorized under

this paragraph (r) to provide care exclusively to patients with Alzheimer's disease.

* * *

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

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

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

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

(c) Of the total number of beds authorized under this subsection, the department shall issue a certificate of need to a hospital currently operating Medicaid-certified acute psychiatric beds for adolescents in DeSoto County, for the establishment of a forty-bed psychiatric residential treatment facility in DeSoto County, provided that the hospital agrees in writing (i) that the hospital shall give priority for the use of those forty (40) beds to Mississippi residents who are presently being treated in out-of-state facilities, and (ii) that no more than fifteen (15) of the beds at the psychiatric residential treatment facility will be certified for participation in the Medicaid program (Section 43-13-101 et seq.), and that no claim will be submitted for Medicaid reimbursement for more than fifteen (15) patients in the

psychiatric residential treatment facility in any day or for any patient in the psychiatric residential treatment facility who is in a bed that is not Medicaid-certified. This written agreement by the recipient of the certificate of need shall be a condition of the issuance of the certificate of need under this paragraph, and the agreement shall be fully binding on any subsequent owner of the psychiatric residential treatment facility if the ownership of the facility is transferred at any time after the issuance of the certificate of need. After this written agreement is executed, the Division of Medicaid and the State Department of Health shall not certify more than fifteen (15) of the beds in the psychiatric residential treatment facility for participation in the Medicaid program. If the psychiatric residential treatment facility violates the terms of the written agreement by admitting or keeping in the facility on a regular or continuing basis more than fifteen (15) patients who are participating in the Medicaid program, the State Department of Health shall revoke the license of the facility, at the time that the department determines, after a hearing complying with due process, that the facility has violated the condition upon which the certificate of need was issued, as provided in this paragraph and in the written agreement.

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

(e) Of the total number of beds authorized under this subsection <u>(3)</u> the department shall issue a certificate of need to a privately owned, nonprofit psychiatric residential treatment facility in Hinds County for an eight-bed expansion of the facility, provided that the facility agrees in writing that the

facility shall give priority for the use of those eight (8) beds to Mississippi residents who are presently being treated in out-of-state facilities.

(4) (a) From and after July 1, 1993, the department shall not issue a certificate of need to any person for the new construction of any hospital, psychiatric hospital or chemical dependency hospital that will contain any child/adolescent psychiatric or child/adolescent chemical dependency beds, or for the conversion of any other health care facility to a hospital, psychiatric hospital or chemical dependency hospital that will contain any child/adolescent psychiatric or child/adolescent chemical dependency beds, or for the addition of any child/adolescent psychiatric or child/adolescent chemical dependency beds in any hospital, psychiatric hospital or chemical dependency hospital, or for the conversion of any beds of another category in any hospital, psychiatric hospital or chemical dependency hospital to child/adolescent psychiatric or child/adolescent chemical dependency beds, except as hereinafter authorized:

(i) The department may issue certificates of need to any person for any purpose described in this subsection, provided that the hospital, psychiatric hospital or chemical dependency hospital does not participate in the Medicaid program (Section 43-13-101 et seq.) at the time of the application for the certificate of need and the owner of the hospital, psychiatric hospital or chemical dependency hospital agrees in writing that the hospital, psychiatric hospital or chemical dependency hospital will not at any time participate in the Medicaid program or admit or keep any patients who are participating in the Medicaid program in the hospital, psychiatric hospital or chemical dependency hospital. This written agreement by the recipient of the certificate of need shall be fully binding on any subsequent owner of the hospital, psychiatric hospital or chemical dependency hospital, if the ownership of the facility is transferred at any time after the issuance of the certificate of need. Agreement

that the hospital, psychiatric hospital or chemical dependency hospital will not participate in the Medicaid program shall be a condition of the issuance of a certificate of need to any person under this subparagraph (a)(i), and if such hospital, psychiatric hospital or chemical dependency hospital at any time after the issuance of the certificate of need, regardless of the ownership of the facility, participates in the Medicaid program or admits or keeps any patients in the hospital, psychiatric hospital or chemical dependency hospital who are participating in the Medicaid program, the State Department of Health shall revoke the certificate of need, if it is still outstanding, and shall deny or revoke the license of the hospital, psychiatric hospital or chemical dependency hospital, at the time that the department determines, after a hearing complying with due process, that the hospital, psychiatric hospital or chemical dependency hospital has failed to comply with any of the conditions upon which the certificate of need was issued, as provided in this subparagraph and in the written agreement by the recipient of the certificate of need.

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

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

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

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

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

certificate of need shall be fully binding on any subsequent owner of the hospital if the ownership of the hospital is transferred at any time after the issuance of the certificate of need. Agreement that the adult psychiatric beds will not be certified for participation in the Medicaid program shall be a condition of the issuance of a certificate of need to any person under this subparagraph (a)(v), and if such hospital at any time after the issuance of the certificate of need, regardless of the ownership of the hospital, has any of such adult psychiatric beds certified for participation in the Medicaid program or admits or keeps any Medicaid patients in such adult psychiatric beds, the State Department of Health shall revoke the certificate of need, if it is still outstanding, and shall deny or revoke the license of the hospital at the time that the department determines, after a hearing complying with due process, that the hospital has failed to comply with any of the conditions upon which the certificate of need was issued, as provided in this subparagraph and in the written agreement by the recipient of the certificate of need.

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

(b) From and after July 1, 1990, no hospital, psychiatric hospital or chemical dependency hospital shall be authorized to add any child/adolescent psychiatric or

child/adolescent chemical dependency beds or convert any beds of another category to child/adolescent psychiatric or child/adolescent chemical dependency beds without a certificate of need under the authority of subsection (1)(c) of this section.

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

(6) The State Department of Health shall issue a certificate of need to a Mississippi corporation qualified to manage a long-term care hospital as defined in Section 41-7-173(h)(xii) in Harrison County, not to exceed eighty (80) beds, including any necessary renovation or construction required for licensure and certification, provided that the recipient of the certificate of need agrees in writing that the long-term care hospital will not at any time participate in the Medicaid program (Section 43-13-101 et seq.) or admit or keep any patients in the long-term care hospital who are participating in the Medicaid program. This written agreement by the recipient of the certificate of need shall be fully binding on any subsequent owner of the long-term care hospital, if the ownership of the facility is transferred at any time after the issuance of the certificate of need. Agreement that the long-term care hospital will not participate in the Medicaid program shall be a condition of the issuance of a certificate of need to any person under this subsection (6), and if such long-term care hospital at any time after the issuance of the certificate of need, regardless of the ownership of the facility, participates in the Medicaid program or admits or keeps any patients in the facility who are participating in the Medicaid program, the State Department of Health shall revoke the certificate of need, if it is still outstanding, and shall deny or revoke the license of the long-term care hospital, at the time that the department determines, after a hearing complying with due process, that the facility has failed to comply with any of the conditions upon which the certificate of need was issued, as provided in this subsection and in the written agreement by the

recipient of the certificate of need. For purposes of this subsection, the provision of Section 41-7-193(1) requiring substantial compliance with the projection of need as reported in the current State Health Plan is hereby waived.

(7) The State Department of Health may issue a certificate of need to any hospital in the state to utilize a portion of its beds for the "swing-bed" concept. Any such hospital must be in conformance with the federal regulations regarding such swing-bed concept at the time it submits its application for a certificate of need to the State Department of Health, except that such hospital may have more licensed beds or a higher average daily census (ADC) than the maximum number specified in federal regulations for participation in the swing-bed program. Any hospital meeting all federal requirements for participation in the swing-bed program which receives such certificate of need shall render services provided under the swing-bed concept to any patient eligible for Medicare (Title XVIII of the Social Security Act) who is certified by a physician to be in need of such services, and no such hospital shall permit any patient who is eligible for both Medicaid and Medicare or eligible only for Medicaid to stay in the swing beds of the hospital for more than thirty (30) days per admission unless the hospital receives prior approval for such patient from the Division of Medicaid, Office of the Governor. Any hospital having more licensed beds or a higher average daily census (ADC) than the maximum number specified in federal regulations for participation in the swing-bed program which receives such certificate of need shall develop a procedure to insure that before a patient is allowed to stay in the swing beds of the hospital, there are no vacant nursing home beds available for that patient located within a fifty-mile radius of the hospital. When any such hospital has a patient staying in the swing beds of the hospital and the hospital receives notice from a nursing home located within such radius that there is a vacant bed available for that patient, the hospital shall transfer the patient to the nursing home within a reasonable time after receipt

of the notice. Any hospital which is subject to the requirements of the two (2) preceding sentences of this subsection may be suspended from participation in the swing-bed program for a reasonable period of time by the State Department of Health if the department, after a hearing complying with due process, determines that the hospital has failed to comply with any of those requirements.

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

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

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

(11) The new construction, renovation or expansion of or addition to any health care facility defined in subparagraph (ii) (psychiatric hospital), subparagraph (iv) (skilled nursing facility), subparagraph (vi) (intermediate care facility), subparagraph (viii) (intermediate care facility for the mentally retarded) and subparagraph (x) (psychiatric residential treatment

facility) of Section 41-7-173(h) which is owned by the State of Mississippi and under the direction and control of the State Department of Mental Health, and the addition of new beds or the conversion of beds from one category to another in any such defined health care facility which is owned by the State of Mississippi and under the direction and control of the State Department of Mental Health, shall not require the issuance of a certificate of need under Section 41-7-171 et seq., notwithstanding any provision in Section 41-7-171 et seq. to the contrary.

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

(13) The new construction of a nursing facility or nursing facility beds or the conversion of other beds to nursing facility beds shall not require the issuance of a certificate of need, notwithstanding any provision in Section 41-7-171 et seq. to the contrary, if the conditions of this subsection are met.

(a) Before any construction or conversion may be undertaken without a certificate of need, the owner of the nursing facility, in the case of an existing facility, or the applicant to construct a nursing facility, in the case of new construction, first must file a written notice of intent and sign a written agreement with the State Department of Health that the entire nursing facility will not at any time participate in or have any beds certified for participation in the Medicaid program (Section 43-13-101 et seq.), will not admit or keep any patients in the nursing facility who are participating in the Medicaid program, and will not submit any claim for Medicaid reimbursement for any patient in the facility. This written agreement by the owner or applicant shall be a condition of exercising the authority under this subsection without a certificate of need, and the agreement

shall be fully binding on any subsequent owner of the nursing facility if the ownership of the facility is transferred at any time after the agreement is signed. After the written agreement is signed, the Division of Medicaid and the State Department of Health shall not certify any beds in the nursing facility for participation in the Medicaid program. If the nursing facility violates the terms of the written agreement by participating in the Medicaid program, having any beds certified for participation in the Medicaid program, admitting or keeping any patient in the facility who is participating in the Medicaid program, or submitting any claim for Medicaid reimbursement for any patient in the facility, the State Department of Health shall revoke the license of the nursing facility at the time that the department determines, after a hearing complying with due process, that the facility has violated the terms of the written agreement.

(b) For the purposes of this subsection, participation in the Medicaid program by a nursing facility includes Medicaid reimbursement of coinsurance and deductibles for recipients who are qualified Medicare beneficiaries and/or those who are dually eligible. Any nursing facility exercising the authority under this subsection may not bill or submit a claim to the Division of Medicaid for services to qualified Medicare beneficiaries and/or those who are dually eligible.

(c) The new construction of a nursing facility or nursing facility beds or the conversion of other beds to nursing facility beds described in this section must be either a part of a completely new continuing care retirement community, as described in the latest edition of the Mississippi State Health Plan, or an addition to existing personal care and independent living components, and so that the completed project will be a continuing care retirement community, containing (i) independent living accommodations, (ii) personal care beds, and (iii) the nursing home facility beds. The three (3) components must be located on a single site and be operated as one (1) inseparable facility. The nursing facility component must contain a minimum of thirty (30)

beds. Any nursing facility beds authorized by this section will not be counted against the bed need set forth in the State Health Plan, as identified in Section 41-7-171, et seq.

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

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

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

SECTION 3. Section 1 of this act shall take effect and be in force from and after June 30, 1999, and Section 2 of this act shall take effect and be in force from and after July 1, 1999.

Further, amend by striking the title in its entirety and inserting in lieu thereof the following:

AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO DIRECT THE DIVISION OF MEDICAID TO DEVELOP AND IMPLEMENT A REFERRAL PROCESS FOR LONG-TERM CARE ALTERNATIVES FOR MEDICAID BENEFICIARIES AND APPLICANTS; TO PROVIDE THAT NO MEDICAID BENEFICIARY SHALL BE ADMITTED TO A MEDICAID-CERTIFIED NURSING FACILITY UNLESS A LICENSED PHYSICIAN CERTIFIES ON A STANDARDIZED FORM THAT NURSING FACILITY CARE IS APPROPRIATE FOR THAT PERSON; TO PROVIDE THAT THE PHYSICIAN MUST FORWARD A COPY OF HIS CERTIFICATION TO THE DIVISION OF MEDICAID WITHIN 24 HOURS; TO REQUIRE THE DIVISION TO DETERMINE, THROUGH AN ASSESSMENT OF THE APPLICANT CONDUCTED WITHIN TWO BUSINESS DAYS AFTER RECEIPT OF THE PHYSICIAN'S CERTIFICATION, WHETHER THE APPLICANT ALSO COULD LIVE APPROPRIATELY AND COST-EFFECTIVELY AT HOME OR IN SOME OTHER COMMUNITY-BASED SETTING IF HOME- OR COMMUNITY-BASED SERVICES WERE AVAILABLE TO THE APPLICANT; TO PROVIDE THAT IF THE DIVISION

DETERMINES THAT A HOME- OR OTHER COMMUNITY-BASED SETTING IS APPROPRIATE AND COST-EFFECTIVE, IT SHALL ADVISE THE APPLICANT THAT A HOME- OR OTHER COMMUNITY-BASED SETTING IS APPROPRIATE AND PROVIDE A PROPOSED CARE PLAN FOR THE APPLICANT; TO PROVIDE THAT THE DIVISION MAY PROVIDE THE SERVICES FOR THE APPLICANT DIRECTLY OR THROUGH CONTRACT WITH CASE MANAGERS FROM THE LOCAL AREA AGENCIES ON AGING; TO PROVIDE THAT THE DIVISION SHALL EXPAND HOME- AND COMMUNITY-BASED SERVICES OVER A FIVE-YEAR PERIOD; TO DELETE THE REQUIREMENT THAT THE DIVISION PROVIDE HOME- AND COMMUNITY-BASED SERVICES UNDER A COOPERATIVE AGREEMENT WITH THE DEPARTMENT OF HUMAN SERVICES; TO AMEND SECTION 41-7-191, MISSISSIPPI CODE OF 1972, TO DELETE THE RESTRICTIONS ON PARTICIPATION IN THE MEDICAID PROGRAM FOR NURSING HOME BEDS THAT WERE AUTHORIZED BY CERTIFICATES OF NEED; TO EXTEND THE PERIOD OF TIME FOR THE ISSUANCE OF CERTIFICATES OF NEED FOR NURSING FACILITY BEDS IN CERTAIN COUNTIES; TO PROVIDE THAT THE STATE DEPARTMENT OF HEALTH SHALL ISSUE CERTIFICATES OF NEED DURING EACH OF THE NEXT FOUR FISCAL YEARS FOR THE CONSTRUCTION OR EXPANSION OF NURSING FACILITY BEDS IN EACH COUNTY IN THE STATE HAVING A NEED FOR 50 OR MORE ADDITIONAL NURSING FACILITY BEDS, NOT TO EXCEED 60 BEDS FOR EACH CERTIFICATE OF NEED; TO PROVIDE THAT DURING EACH OF THE NEXT FOUR FISCAL YEARS, THE DEPARTMENT SHALL ISSUE SIX CERTIFICATES OF NEED FOR NEW NURSING FACILITY BEDS, WITH ONE CERTIFICATE OF NEED TO BE ISSUED FOR NEW BEDS IN THE COUNTY IN EACH OF THE FOUR LONG-TERM CARE PLANNING DISTRICTS DESIGNATED IN THE STATE HEALTH PLAN THAT HAS THE HIGHEST NEED IN THE DISTRICT FOR THOSE BEDS, AND TWO CERTIFICATES OF NEED TO BE ISSUED FOR NEW BEDS IN THE TWO COUNTIES FROM THE STATE AT LARGE THAT HAVE THE HIGHEST NEED IN THE STATE FOR THOSE BEDS; TO PROVIDE THAT DURING FISCAL YEAR 2000, THE DEPARTMENT ALSO SHALL ISSUE A CERTIFICATE OF NEED FOR NEW NURSING FACILITY BEDS IN AMITE COUNTY AND A CERTIFICATE OF NEED FOR NEW NURSING FACILITY BEDS IN CARROLL COUNTY; TO PROVIDE THAT THE CERTIFICATE OF NEED ISSUED IN EACH DISTRICT DURING EACH FISCAL YEAR SHALL FIRST BE AVAILABLE FOR NURSING FACILITY BEDS IN THE COUNTY IN THE DISTRICT HAVING THE HIGHEST NEED FOR THOSE BEDS; TO PROVIDE THAT IF THERE ARE NO APPLICATIONS FOR A CERTIFICATE OF NEED IN THE COUNTY HAVING THE HIGHEST NEED, THEN THE CERTIFICATE OF NEED SHALL BE AVAILABLE FOR NURSING FACILITY BEDS IN OTHER COUNTIES IN THE DISTRICT IN DESCENDING ORDER OF THE NEED FOR THOSE BEDS, UNTIL AN APPLICATION IS RECEIVED FOR BEDS IN AN ELIGIBLE COUNTY IN THE DISTRICT; TO PROVIDE THAT AFTER A CERTIFICATE OF NEED HAS BEEN ISSUED FOR NURSING FACILITY BEDS IN A COUNTY DURING ANY FISCAL YEAR OF THE FOUR-YEAR PERIOD, A CERTIFICATE OF NEED SHALL NOT BE AVAILABLE AGAIN FOR ADDITIONAL BEDS IN THAT COUNTY DURING THE FOUR-YEAR PERIOD; TO PROVIDE THAT THE DEPARTMENT SHALL ISSUE CERTIFICATES OF NEED DURING THE NEXT TWO FISCAL YEARS FOR THE CONSTRUCTION OR CONVERSION OF NURSING FACILITY BEDS IN EACH OF THE FOUR LONG-TERM CARE PLANNING DISTRICTS TO PROVIDE CARE EXCLUSIVELY TO PATIENTS WITH ALZHEIMER'S DISEASE, NOT TO EXCEED 20 BEDS PER CERTIFICATE OF NEED OR A TOTAL OF 60 BEDS PER DISTRICT; TO PROVIDE THAT THE TOTAL NUMBER OF THOSE BEDS SHALL NOT EXCEED 120 BEDS DURING ANY FISCAL YEAR, AND THE TOTAL NUMBER OF THOSE BEDS IN ANY DISTRICT SHALL NOT EXCEED 40 BEDS DURING ANY FISCAL YEAR; TO DIRECT THE STATE DEPARTMENT OF HEALTH TO DEVELOP AND PRESCRIBE STANDARDS AND REQUIREMENTS THAT MUST BE MET WITH REGARD TO THOSE NURSING FACILITY BEDS FOR ALZHEIMER'S PATIENTS; TO AUTHORIZE THE STATE DEPARTMENT OF HEALTH TO ISSUE CERTIFICATES OF NEED FOR THE CONSTRUCTION OR EXPANSION OF CHILD PSYCHIATRIC BEDS AT THE UNIVERSITY MEDICAL CENTER; TO PROVIDE THAT NOTHING IN THE CERTIFICATE OF NEED LAW SHALL PREVENT ANY NURSING FACILITY FROM DESIGNATING EXISTING BEDS IN THE FACILITY AS BEDS FOR PROVIDING CARE EXCLUSIVELY TO PATIENTS WITH ALZHEIMER'S DISEASE; AND FOR RELATED PURPOSES.

CONFEREES FOR THE SENATE:

X_____
Terry C. Burton

CONFEREES FOR THE HOUSE:

X_____
Bobby Moody

X_____
Alan Nunnelee

X_____
Mary H. Coleman

X_____
Jim Bean

X_____
D. Stephen Holland