

By: Senator(s) Huggins

To: Public Health and  
Welfare; Appropriations

COMMITTEE SUBSTITUTE  
FOR  
SENATE BILL NO. 2189

1 AN ACT RELATING TO THE MISSISSIPPI MEDICAID LAW; TO AMEND  
2 SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO AUTHORIZE  
3 UNLIMITED DAY REIMBURSEMENT FOR DISPROPORTIONATE SHARE PROGRAM  
4 HOSPITALS FOR ELIGIBLE CHILDREN UNDER THE AGE OF SIX ONLY IF  
5 CERTIFIED AS MEDICALLY NECESSARY, TO AUTHORIZE THE DIVISION OF  
6 MEDICAID TO ESTABLISH A MEDICARE UPPER PAYMENT LIMITS PROGRAM FOR  
7 OUTPATIENT HOSPITAL SERVICES, TO DELETE SPECIFIC FEE INCREASES FOR  
8 PERIODIC SCREENING AND DIAGNOSTIC SERVICES, TO REVISE THE  
9 CONDITIONS FOR REIMBURSEMENT OF THE COST OF EYEGLASSES FOR  
10 RECIPIENTS, TO CLARIFY THE REQUIREMENT FOR DISPROPORTIONATE SHARE  
11 PROGRAM HOSPITALS TO PARTICIPATE IN THE FEDERAL INTERGOVERNMENTAL  
12 TRANSFER PROGRAM, TO CHANGE CERTAIN REFERENCES TO THE FEDERAL  
13 INDIVIDUALS WITH DISABILITIES EDUCATION ACT, TO AUTHORIZE MEDICAID  
14 REIMBURSEMENT TO RURAL HEALTH CENTERS FOR AMBULATORY SERVICES, TO  
15 AUTHORIZE MEDICAID REIMBURSEMENT TO CHIROPRACTORS FOR X-RAYS  
16 PERFORMED TO DOCUMENT CONDITIONS, AND TO AUTHORIZE THE DIVISION TO  
17 DEVELOP AND IMPLEMENT A DISEASE MANAGEMENT PROGRAM; TO AMEND  
18 SECTION 43-13-121, MISSISSIPPI CODE OF 1972, TO CLARIFY AND REVISE  
19 THE CONDITIONS FOR DENYING OR REVOKING PROVIDER ENROLLMENT IN THE  
20 MEDICAID PROGRAM; TO AMEND SECTION 43-13-123, MISSISSIPPI CODE OF  
21 1972, TO CLARIFY THAT THE DIVISION SHALL OBTAIN SERVICES PURSUANT  
22 TO REGULATIONS OF THE PERSONAL SERVICE CONTRACT REVIEW BOARD; TO  
23 AMEND SECTION 43-13-145, MISSISSIPPI CODE OF 1972, TO CLARIFY THAT  
24 THE MEDICAID ASSESSMENT IS TO BE ON ALL LICENSED OR CERTIFIED  
25 NURSING FACILITY BEDS IN THE STATE; TO AMEND SECTION 41-7-191,  
26 MISSISSIPPI CODE OF 1972, TO DELETE THE REQUIREMENT THAT THE  
27 DIVISION OF MEDICAID FURNISH A CERTAIN RESIDENTIAL FACILITY THE  
28 NAMES AND MEDICAL INFORMATION ABOUT RECIPIENTS RECEIVING SERVICES  
29 OUT OF STATE; AND FOR RELATED PURPOSES.

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

31 **SECTION 1.** Section 43-13-117, Mississippi Code of 1972, is  
32 amended as follows:

33 43-13-117. Medical assistance as authorized by this article  
34 shall include payment of part or all of the costs, at the  
35 discretion of the division or its successor, with approval of the  
36 Governor, of the following types of care and services rendered to  
37 eligible applicants who shall have been determined to be eligible  
38 for such care and services, within the limits of state  
39 appropriations and federal matching funds:

40 (1) Inpatient hospital services.



41                   (a) The division shall allow thirty (30) days of  
42 inpatient hospital care annually for all Medicaid recipients.  
43 Precertification of inpatient days must be obtained as required by  
44 the division. The division shall be authorized to allow unlimited  
45 days in disproportionate hospitals as defined by the division for  
46 eligible infants under the age of six (6) years if certified as  
47 medically necessary as required by the division.

48                   (b) From and after July 1, 1994, the Executive  
49 Director of the Division of Medicaid shall amend the Mississippi  
50 Title XIX Inpatient Hospital Reimbursement Plan to remove the  
51 occupancy rate penalty from the calculation of the Medicaid  
52 Capital Cost Component utilized to determine total hospital costs  
53 allocated to the Medicaid program.

54                   (c) Hospitals will receive an additional payment  
55 for the implantable programmable baclofen drug pump used to treat  
56 spasticity which is implanted on an inpatient basis. The payment  
57 pursuant to written invoice will be in addition to the facility's  
58 per diem reimbursement and will represent a reduction of costs on  
59 the facility's annual cost report, and shall not exceed Ten  
60 Thousand Dollars (\$10,000.00) per year per recipient. This  
61 paragraph (c) shall stand repealed on July 1, 2005.

62                   (2) Outpatient hospital services.

63                   (a) Provided that where the same services are  
64 reimbursed as clinic services, the division may revise the rate or  
65 methodology of outpatient reimbursement to maintain consistency,  
66 efficiency, economy and quality of care. The division shall  
67 develop a Medicaid-specific cost-to-charge ratio calculation from  
68 data provided by hospitals to determine an allowable rate payment  
69 for outpatient hospital services, and shall submit a report  
70 thereon to the Medical Advisory Committee on or before December 1,  
71 1999. The committee shall make a recommendation on the specific  
72 cost-to-charge reimbursement method for outpatient hospital  
73 services to the 2000 Regular Session of the Legislature.



74                   (b) In addition to reimbursement methodology for  
75 outpatient hospital services, the division may establish a  
76 Medicare upper payment limits program for outpatient hospital  
77 services in accordance with applicable federal law and  
78 regulations. The division may assess each hospital for the sole  
79 purpose of financing the state portion of the Medicare upper  
80 payment limits program for outpatient hospital services based on  
81 appropriate methodology consistent with federal law and  
82 regulations. This assessment will remain in effect as long as the  
83 state participates in a Medicare upper payment limits program for  
84 outpatient hospital services.

85                   (3) Laboratory and x-ray services.

86                   (4) Nursing facility services.

87                   (a) The division shall make full payment to  
88 nursing facilities for each day, not exceeding fifty-two (52) days  
89 per year, that a patient is absent from the facility on home  
90 leave. Payment may be made for the following home leave days in  
91 addition to the fifty-two-day limitation: Christmas, the day  
92 before Christmas, the day after Christmas, Thanksgiving, the day  
93 before Thanksgiving and the day after Thanksgiving.

94                   (b) From and after July 1, 1997, the division  
95 shall implement the integrated case-mix payment and quality  
96 monitoring system, which includes the fair rental system for  
97 property costs and in which recapture of depreciation is  
98 eliminated. The division may reduce the payment for hospital  
99 leave and therapeutic home leave days to the lower of the case-mix  
100 category as computed for the resident on leave using the  
101 assessment being utilized for payment at that point in time, or a  
102 case-mix score of 1.000 for nursing facilities, and shall compute  
103 case-mix scores of residents so that only services provided at the  
104 nursing facility are considered in calculating a facility's per  
105 diem.



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

109 (d) When a facility of a category that does not  
110 require a certificate of need for construction and that could not  
111 be eligible for Medicaid reimbursement is constructed to nursing  
112 facility specifications for licensure and certification, and the  
113 facility is subsequently converted to a nursing facility pursuant  
114 to a certificate of need that authorizes conversion only and the  
115 applicant for the certificate of need was assessed an application  
116 review fee based on capital expenditures incurred in constructing  
117 the facility, the division shall allow reimbursement for capital  
118 expenditures necessary for construction of the facility that were  
119 incurred within the twenty-four (24) consecutive calendar months  
120 immediately preceding the date that the certificate of need  
121 authorizing such conversion was issued, to the same extent that  
122 reimbursement would be allowed for construction of a new nursing  
123 facility pursuant to a certificate of need that authorizes such  
124 construction. The reimbursement authorized in this subparagraph  
125 (d) may be made only to facilities the construction of which was  
126 completed after June 30, 1989. Before the division shall be  
127 authorized to make the reimbursement authorized in this  
128 subparagraph (d), the division first must have received approval  
129 from the Health Care Financing Administration of the United States  
130 Department of Health and Human Services of the change in the state  
131 Medicaid plan providing for such reimbursement.

132 (e) The division shall develop and implement, not  
133 later than January 1, 2001, a case-mix payment add-on determined  
134 by time studies and other valid statistical data which will  
135 reimburse a nursing facility for the additional cost of caring for  
136 a resident who has a diagnosis of Alzheimer's or other related  
137 dementia and exhibits symptoms that require special care. Any  
138 such case-mix add-on payment shall be supported by a determination



139 of additional cost. The division shall also develop and implement  
140 as part of the fair rental reimbursement system for nursing  
141 facility beds, an Alzheimer's resident bed depreciation enhanced  
142 reimbursement system which will provide an incentive to encourage  
143 nursing facilities to convert or construct beds for residents with  
144 Alzheimer's or other related dementia.

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

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



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

176                   (iii) Explain that such plan and services are  
177 available only if the applicant or the applicant's legal  
178 representative chooses a home- or community-based alternative to  
179 nursing facility care, and that the applicant is free to choose  
180 nursing facility care.

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

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

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

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

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

201           (5) Periodic screening and diagnostic services for  
202 individuals under age twenty-one (21) years as are needed to  
203 identify physical and mental defects and to provide health care



204 treatment and other measures designed to correct or ameliorate  
205 defects and physical and mental illness and conditions discovered  
206 by the screening services regardless of whether these services are  
207 included in the state plan. The division may include in its  
208 periodic screening and diagnostic program those discretionary  
209 services authorized under the federal regulations adopted to  
210 implement Title XIX of the federal Social Security Act, as  
211 amended. The division, in obtaining physical therapy services,  
212 occupational therapy services, and services for individuals with  
213 speech, hearing and language disorders, may enter into a  
214 cooperative agreement with the State Department of Education for  
215 the provision of such services to handicapped students by public  
216 school districts using state funds which are provided from the  
217 appropriation to the Department of Education to obtain federal  
218 matching funds through the division. The division, in obtaining  
219 medical and psychological evaluations for children in the custody  
220 of the State Department of Human Services may enter into a  
221 cooperative agreement with the State Department of Human Services  
222 for the provision of such services using state funds which are  
223 provided from the appropriation to the Department of Human  
224 Services to obtain federal matching funds through the division.

225 \* \* \*

226 (6) Physician's services. The division shall allow  
227 twelve (12) physician visits annually. All fees for physicians'  
228 services that are covered only by Medicaid shall be reimbursed at  
229 ninety percent (90%) of the rate established on January 1, 1999,  
230 and as adjusted each January thereafter, under Medicare (Title  
231 XVIII of the Social Security Act, as amended), and which shall in  
232 no event be less than seventy percent (70%) of the rate  
233 established on January 1, 1994. All fees for physicians' services  
234 that are covered by both Medicare and Medicaid shall be reimbursed  
235 at ten percent (10%) of the adjusted Medicare payment established  
236 on January 1, 1999, and as adjusted each January thereafter, under



237 Medicare (Title XVIII of the Social Security Act, as amended), and  
238 which shall in no event be less than seventy percent (70%) of the  
239 adjusted Medicare payment established on January 1, 1994.

240 (7) (a) Home health services for eligible persons, not  
241 to exceed in cost the prevailing cost of nursing facility  
242 services, not to exceed sixty (60) visits per year. All home  
243 health visits must be precertified as required by the division.

244 (b) Repealed.

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

256 (9) Legend and other drugs as may be determined by the  
257 division. The division may implement a program of prior approval  
258 for drugs to the extent permitted by law. Payment by the division  
259 for covered multiple source drugs shall be limited to the lower of  
260 the upper limits established and published by the Health Care  
261 Financing Administration (HCFA) plus a dispensing fee of Four  
262 Dollars and Ninety-one Cents (\$4.91), or the estimated acquisition  
263 cost (EAC) as determined by the division plus a dispensing fee of  
264 Four Dollars and Ninety-one Cents (\$4.91), or the providers' usual  
265 and customary charge to the general public. The division shall  
266 allow ten (10) prescriptions per month for noninstitutionalized  
267 Medicaid recipients.

268 Payment for other covered drugs, other than multiple source  
269 drugs with HCFA upper limits, shall not exceed the lower of the





270 estimated acquisition cost as determined by the division plus a  
271 dispensing fee of Four Dollars and Ninety-one Cents (\$4.91) or the  
272 providers' usual and customary charge to the general public.

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

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

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

291 (10) Dental care that is an adjunct to treatment of an  
292 acute medical or surgical condition; services of oral surgeons and  
293 dentists in connection with surgery related to the jaw or any  
294 structure contiguous to the jaw or the reduction of any fracture  
295 of the jaw or any facial bone; and emergency dental extractions  
296 and treatment related thereto. On July 1, 1999, all fees for  
297 dental care and surgery under authority of this paragraph (10)  
298 shall be increased to one hundred sixty percent (160%) of the  
299 amount of the reimbursement rate that was in effect on June 30,  
300 1999. It is the intent of the Legislature to encourage more  
301 dentists to participate in the Medicaid program.



302           (11) Eyeglasses for all Medicaid beneficiaries who have  
303 (a) had \* \* \* surgery on the eyeball or ocular muscle which  
304 results in a vision change for which eyeglasses or a change in  
305 eyeglasses is medically indicated within six (6) months of the  
306 surgery and is in accordance with policies established by the  
307 division, or (b) one (1) pair every three (3) years and in  
308 accordance with policies established by the division. In either  
309 instance, the eyeglasses must be prescribed by a physician skilled  
310 in the diseases of the eye or an optometrist, whichever the  
311 beneficiary may select.

312           (12) Intermediate care facility services.

313           (a) The division shall make full payment to all  
314 intermediate care facilities for the mentally retarded for each  
315 day, not exceeding eighty-four (84) days per year, that a patient  
316 is absent from the facility on home leave. Payment may be made  
317 for the following home leave days in addition to the  
318 eighty-four-day limitation: Christmas, the day before Christmas,  
319 the day after Christmas, Thanksgiving, the day before Thanksgiving  
320 and the day after Thanksgiving.

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

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

327           (14) Clinic services. Such diagnostic, preventive,  
328 therapeutic, rehabilitative or palliative services furnished to an  
329 outpatient by or under the supervision of a physician or dentist  
330 in a facility which is not a part of a hospital but which is  
331 organized and operated to provide medical care to outpatients.  
332 Clinic services shall include any services reimbursed as  
333 outpatient hospital services which may be rendered in such a  
334 facility, including those that become so after July 1, 1991. On



335 July 1, 1999, all fees for physicians' services reimbursed under  
336 authority of this paragraph (14) shall be reimbursed at ninety  
337 percent (90%) of the rate established on January 1, 1999, and as  
338 adjusted each January thereafter, under Medicare (Title XVIII of  
339 the Social Security Act, as amended), and which shall in no event  
340 be less than seventy percent (70%) of the rate established on  
341 January 1, 1994. All fees for physicians' services that are  
342 covered by both Medicare and Medicaid shall be reimbursed at ten  
343 percent (10%) of the adjusted Medicare payment established on  
344 January 1, 1999, and as adjusted each January thereafter, under  
345 Medicare (Title XVIII of the Social Security Act, as amended), and  
346 which shall in no event be less than seventy percent (70%) of the  
347 adjusted Medicare payment established on January 1, 1994. On July  
348 1, 1999, all fees for dentists' services reimbursed under  
349 authority of this paragraph (14) shall be increased to one hundred  
350 sixty percent (160%) of the amount of the reimbursement rate that  
351 was in effect on June 30, 1999.

352 (15) Home- and community-based services, as provided  
353 under Title XIX of the federal Social Security Act, as amended,  
354 under waivers, subject to the availability of funds specifically  
355 appropriated therefor by the Legislature. Payment for such  
356 services shall be limited to individuals who would be eligible for  
357 and would otherwise require the level of care provided in a  
358 nursing facility. The home- and community-based services  
359 authorized under this paragraph shall be expanded over a five-year  
360 period beginning July 1, 1999. The division shall certify case  
361 management agencies to provide case management services and  
362 provide for home- and community-based services for eligible  
363 individuals under this paragraph. The home- and community-based  
364 services under this paragraph and the activities performed by  
365 certified case management agencies under this paragraph shall be  
366 funded using state funds that are provided from the appropriation  
367 to the Division of Medicaid and used to match federal funds.



368           (16) Mental health services. Approved therapeutic and  
369 case management services provided by (a) an approved regional  
370 mental health/retardation center established under Sections  
371 41-19-31 through 41-19-39, or by another community mental health  
372 service provider meeting the requirements of the Department of  
373 Mental Health to be an approved mental health/retardation center  
374 if determined necessary by the Department of Mental Health, using  
375 state funds which are provided from the appropriation to the State  
376 Department of Mental Health and used to match federal funds under  
377 a cooperative agreement between the division and the department,  
378 or (b) a facility which is certified by the State Department of  
379 Mental Health to provide therapeutic and case management services,  
380 to be reimbursed on a fee for service basis. Any such services  
381 provided by a facility described in paragraph (b) must have the  
382 prior approval of the division to be reimbursable under this  
383 section. After June 30, 1997, mental health services provided by  
384 regional mental health/retardation centers established under  
385 Sections 41-19-31 through 41-19-39, or by hospitals as defined in  
386 Section 41-9-3(a) and/or their subsidiaries and divisions, or by  
387 psychiatric residential treatment facilities as defined in Section  
388 43-11-1, or by another community mental health service provider  
389 meeting the requirements of the Department of Mental Health to be  
390 an approved mental health/retardation center if determined  
391 necessary by the Department of Mental Health, shall not be  
392 included in or provided under any capitated managed care pilot  
393 program provided for under paragraph (24) of this section.

394           (17) Durable medical equipment services and medical  
395 supplies. Precertification of durable medical equipment and  
396 medical supplies must be obtained as required by the division.  
397 The Division of Medicaid may require durable medical equipment  
398 providers to obtain a surety bond in the amount and to the  
399 specifications as established by the Balanced Budget Act of 1997.



400           (18) (a) Notwithstanding any other provision of this  
401 section to the contrary, the division shall make additional  
402 reimbursement to hospitals which serve a disproportionate share of  
403 low-income patients and which meet the federal requirements for  
404 such payments as provided in Section 1923 of the federal Social  
405 Security Act and any applicable regulations. However, from and  
406 after January 1, 1999, no public hospital shall participate in the  
407 Medicaid disproportionate share program unless the public hospital  
408 participates in an intergovernmental transfer program as provided  
409 in Section 1903 of the federal Social Security Act and any  
410 applicable regulations. Administration and support for  
411 participating hospitals shall be provided by the Mississippi  
412 Hospital Association.

413           (b) The division shall establish a Medicare Upper  
414 Payment Limits Program as defined in Section 1902 (a) (30) of the  
415 federal Social Security Act and any applicable federal  
416 regulations. The division shall assess each hospital for the sole  
417 purpose of financing the state portion of the Medicare Upper  
418 Payment Limits Program. This assessment shall be based on  
419 Medicaid utilization, or other appropriate method consistent with  
420 federal regulations, and will remain in effect as long as the  
421 state participates in the Medicare Upper Payment Limits Program.  
422 The division shall make additional reimbursement to hospitals for  
423 the Medicare Upper Payment Limits as defined in Section 1902 (a)  
424 (30) of the federal Social Security Act and any applicable federal  
425 regulations. This paragraph (b) shall stand repealed from and  
426 after July 1, 2005.

427           (c) The division shall contract with the  
428 Mississippi Hospital Association to provide administrative support  
429 for the operation of the disproportionate share hospital program  
430 and the Medicare Upper Payment Limits Program. This paragraph (c)  
431 shall stand repealed from and after July 1, 2005.



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

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

457           (20) Home- and community-based services for physically  
458 disabled approved services as allowed by a waiver from the United  
459 States Department of Health and Human Services for home- and  
460 community-based services for physically disabled people using  
461 state funds which are provided from the appropriation to the State  
462 Department of Rehabilitation Services and used to match federal  
463 funds under a cooperative agreement between the division and the  
464 department, provided that funds for these services are



465 specifically appropriated to the Department of Rehabilitation  
466 Services.

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

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

482 (23) Inpatient psychiatric services. Inpatient  
483 psychiatric services to be determined by the division for  
484 recipients under age twenty-one (21) which are provided under the  
485 direction of a physician in an inpatient program in a licensed  
486 acute care psychiatric facility or in a licensed psychiatric  
487 residential treatment facility, before the recipient reaches age  
488 twenty-one (21) or, if the recipient was receiving the services  
489 immediately before he reached age twenty-one (21), before the  
490 earlier of the date he no longer requires the services or the date  
491 he reaches age twenty-two (22), as provided by federal  
492 regulations. Precertification of inpatient days and residential  
493 treatment days must be obtained as required by the division.

494 (24) Managed care services in a program to be developed  
495 by the division by a public or private provider. If managed care  
496 services are provided by the division to Medicaid recipients, and  
497 those managed care services are operated, managed and controlled



498 by and under the authority of the division, the division shall be  
499 responsible for educating the Medicaid recipients who are  
500 participants in the managed care program regarding the manner in  
501 which the participants should seek health care under the program.  
502 Notwithstanding any other provision in this article to the  
503 contrary, the division shall establish rates of reimbursement to  
504 providers rendering care and services authorized under this  
505 paragraph (24), and may revise such rates of reimbursement without  
506 amendment to this section by the Legislature for the purpose of  
507 achieving effective and accessible health services, and for  
508 responsible containment of costs.

509 (25) Birthing center services.

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

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

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

528 (29) The Division of Medicaid may apply for a waiver  
529 from the Department of Health and Human Services for home- and  
530 community-based services for developmentally disabled people using





531 state funds which are provided from the appropriation to the State  
532 Department of Mental Health and used to match federal funds under  
533 a cooperative agreement between the division and the department,  
534 provided that funds for these services are specifically  
535 appropriated to the Department of Mental Health.

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

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

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

550 (33) Podiatrist services.

551 (34) The division shall make application to the United  
552 States Health Care Financing Administration for a waiver to  
553 develop a program of services to personal care and assisted living  
554 homes in Mississippi. This waiver shall be completed by December  
555 1, 1999.

556 (35) Services and activities authorized in Sections  
557 43-27-101 and 43-27-103, using state funds that are provided from  
558 the appropriation to the State Department of Human Services and  
559 used to match federal funds under a cooperative agreement between  
560 the division and the department.

561 (36) Nonemergency transportation services for  
562 Medicaid-eligible persons, to be provided by the Division of  
563 Medicaid. The division may contract with additional entities to



564 administer nonemergency transportation services as it deems  
565 necessary. All providers shall have a valid driver's license,  
566 vehicle inspection sticker, valid vehicle license tags and a  
567 standard liability insurance policy covering the vehicle.

568 (37) [Deleted]

569 (38) Chiropractic services: a chiropractor's manual  
570 manipulation of the spine to correct a subluxation, if x-ray  
571 demonstrates that a subluxation exists and if the subluxation has  
572 resulted in a neuromusculoskeletal condition for which  
573 manipulation is appropriate treatment, and related spinal x-rays  
574 performed to document these conditions. Reimbursement for  
575 chiropractic services shall not exceed Seven Hundred Dollars  
576 (\$700.00) per year per beneficiary.

577 (39) Dually eligible Medicare/Medicaid beneficiaries.  
578 The division shall pay the Medicare deductible and ten percent  
579 (10%) coinsurance amounts for services available under Medicare  
580 for the duration and scope of services otherwise available under  
581 the Medicaid program.

582 (40) [Deleted]

583 (41) Services provided by the State Department of  
584 Rehabilitation Services for the care and rehabilitation of persons  
585 with spinal cord injuries or traumatic brain injuries, as allowed  
586 under waivers from the United States Department of Health and  
587 Human Services, using up to seventy-five percent (75%) of the  
588 funds that are appropriated to the Department of Rehabilitation  
589 Services from the Spinal Cord and Head Injury Trust Fund  
590 established under Section 37-33-261 and used to match federal  
591 funds under a cooperative agreement between the division and the  
592 department.

593 (42) Notwithstanding any other provision in this  
594 article to the contrary, the division is hereby authorized to  
595 develop a population health management program for women and  
596 children health services through the age of two (2). This program



597 is primarily for obstetrical care associated with low birth weight  
598 and pre-term babies. In order to effect cost savings, the  
599 division may develop a revised payment methodology which may  
600 include at-risk capitated payments.

601 (43) The division shall provide reimbursement,  
602 according to a payment schedule developed by the division, for  
603 smoking cessation medications for pregnant women during their  
604 pregnancy and other Medicaid-eligible women who are of  
605 child-bearing age.

606 (44) Nursing facility services for the severely  
607 disabled.

608 (a) Severe disabilities include, but are not  
609 limited to, spinal cord injuries, closed head injuries and  
610 ventilator dependent patients.

611 (b) Those services must be provided in a long-term  
612 care nursing facility dedicated to the care and treatment of  
613 persons with severe disabilities, and shall be reimbursed as a  
614 separate category of nursing facilities.

615 (45) Physician assistant services. Services furnished  
616 by a physician assistant who is licensed by the State Board of  
617 Medical Licensure and is practicing with physician supervision  
618 under regulations adopted by the board, under regulations adopted  
619 by the division. Reimbursement for those services shall not  
620 exceed ninety percent (90%) of the reimbursement rate for  
621 comparable services rendered by a physician.

622 (46) The division shall make application to the federal  
623 Health Care Financing Administration for a waiver to develop and  
624 provide services for children with serious emotional disturbances  
625 as defined in Section 43-14-1(1), which may include home- and  
626 community-based services, case management services or managed care  
627 services through mental health providers certified by the  
628 Department of Mental Health. The division may implement and  
629 provide services under this waived program only if funds for



630 these services are specifically appropriated for this purpose by  
631 the Legislature, or if funds are voluntarily provided by affected  
632 agencies.

633 (47) Notwithstanding any other provision in this  
634 article to the contrary, the division is hereby authorized to  
635 develop and implement disease management programs, including the  
636 use of grants, waivers, demonstrations or other projects as  
637 necessary.

638 Notwithstanding any provision of this article, except as  
639 authorized in the following paragraph and in Section 43-13-139,  
640 neither (a) the limitations on quantity or frequency of use of or  
641 the fees or charges for any of the care or services available to  
642 recipients under this section, nor (b) the payments or rates of  
643 reimbursement to providers rendering care or services authorized  
644 under this section to recipients, may be increased, decreased or  
645 otherwise changed from the levels in effect on July 1, 1999,  
646 unless such is authorized by an amendment to this section by the  
647 Legislature. However, the restriction in this paragraph shall not  
648 prevent the division from changing the payments or rates of  
649 reimbursement to providers without an amendment to this section  
650 whenever such changes are required by federal law or regulation,  
651 or whenever such changes are necessary to correct administrative  
652 errors or omissions in calculating such payments or rates of  
653 reimbursement.

654 Notwithstanding any provision of this article, no new groups  
655 or categories of recipients and new types of care and services may  
656 be added without enabling legislation from the Mississippi  
657 Legislature, except that the division may authorize such changes  
658 without enabling legislation when such addition of recipients or  
659 services is ordered by a court of proper authority. The director  
660 shall keep the Governor advised on a timely basis of the funds  
661 available for expenditure and the projected expenditures. In the  
662 event current or projected expenditures can be reasonably



663 anticipated to exceed the amounts appropriated for any fiscal  
664 year, the Governor, after consultation with the director, shall  
665 discontinue any or all of the payment of the types of care and  
666 services as provided herein which are deemed to be optional  
667 services under Title XIX of the federal Social Security Act, as  
668 amended, for any period necessary to not exceed appropriated  
669 funds, and when necessary shall institute any other cost  
670 containment measures on any program or programs authorized under  
671 the article to the extent allowed under the federal law governing  
672 such program or programs, it being the intent of the Legislature  
673 that expenditures during any fiscal year shall not exceed the  
674 amounts appropriated for such fiscal year.

675         Notwithstanding any other provision of this article, it shall  
676 be the duty of each nursing facility, intermediate care facility  
677 for the mentally retarded, psychiatric residential treatment  
678 facility, and nursing facility for the severely disabled that is  
679 participating in the medical assistance program to keep and  
680 maintain books, documents, and other records as prescribed by the  
681 Division of Medicaid in substantiation of its cost reports for a  
682 period of three (3) years after the date of submission to the  
683 Division of Medicaid of an original cost report, or three (3)  
684 years after the date of submission to the Division of Medicaid of  
685 an amended cost report.

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

688         43-13-121. (1) The division is authorized and empowered to  
689 administer a program of medical assistance under the provisions of  
690 this article, and to do the following:

691             (a) Adopt and promulgate reasonable rules, regulations  
692 and standards, with approval of the Governor, and in accordance  
693 with the Administrative Procedures Law, Section 25-43-1 et seq.:



694 (i) Establishing methods and procedures as may be  
695 necessary for the proper and efficient administration of this  
696 article;

697 (ii) Providing medical assistance to all qualified  
698 recipients under the provisions of this article as the division  
699 may determine and within the limits of appropriated funds;

700 (iii) Establishing reasonable fees, charges and  
701 rates for medical services and drugs; and in doing so shall fix  
702 all such fees, charges and rates at the minimum levels absolutely  
703 necessary to provide the medical assistance authorized by this  
704 article, and shall not change any such fees, charges or rates  
705 except as may be authorized in Section 43-13-117;

706 (iv) Providing for fair and impartial hearings;

707 (v) Providing safeguards for preserving the  
708 confidentiality of records; and

709 (vi) For detecting and processing fraudulent  
710 practices and abuses of the program;

711 (b) Receive and expend state, federal and other funds  
712 in accordance with court judgments or settlements and agreements  
713 between the State of Mississippi and the federal government, the  
714 rules and regulations promulgated by the division, with the  
715 approval of the Governor, and within the limitations and  
716 restrictions of this article and within the limits of funds  
717 available for such purpose;

718 (c) Subject to the limits imposed by this article, to  
719 submit a plan for medical assistance to the federal Department of  
720 Health and Human Services for approval pursuant to the provisions  
721 of the Social Security Act, to act for the state in making  
722 negotiations relative to the submission and approval of such plan,  
723 to make such arrangements, not inconsistent with the law, as may  
724 be required by or pursuant to federal law to obtain and retain  
725 such approval and to secure for the state the benefits of the  
726 provisions of such law;



727 No agreements, specifically including the general plan for  
728 the operation of the Medicaid program in this state, shall be made  
729 by and between the division and the Department of Health and Human  
730 Services unless the Attorney General of the State of Mississippi  
731 has reviewed the agreements, specifically including the  
732 operational plan, and has certified in writing to the Governor and  
733 to the director of the division that the agreements, including the  
734 plan of operation, have been drawn strictly in accordance with the  
735 terms and requirements of this article;

736 (d) Pursuant to the purposes and intent of this article  
737 and in compliance with its provisions, provide for aged persons  
738 otherwise eligible for the benefits provided under Title XVIII of  
739 the federal Social Security Act by expenditure of funds available  
740 for such purposes;

741 (e) To make reports to the federal Department of Health  
742 and Human Services as from time to time may be required by such  
743 federal department and to the Mississippi Legislature as  
744 hereinafter provided;

745 (f) Define and determine the scope, duration and amount  
746 of medical assistance which may be provided in accordance with  
747 this article and establish priorities therefor in conformity with  
748 this article;

749 (g) Cooperate and contract with other state agencies  
750 for the purpose of coordinating medical assistance rendered under  
751 this article and eliminating duplication and inefficiency in the  
752 program;

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

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

757 (j) To recover any and all payments incorrectly made by  
758 the division or by the Medicaid Commission to a recipient or  
759 provider from the recipient or provider receiving the payments;



760           (k) To recover any and all payments by the division or  
761 by the Medicaid Commission fraudulently obtained by a recipient or  
762 provider. Additionally, if recovery of any payments fraudulently  
763 obtained by a recipient or provider is made in any court, then,  
764 upon motion of the Governor, the judge of the court may award  
765 twice the payments recovered as damages;

766           (1) Have full, complete and plenary power and authority  
767 to conduct such investigations as it may deem necessary and  
768 requisite of alleged or suspected violations or abuses of the  
769 provisions of this article or of the regulations adopted hereunder  
770 including, but not limited to, fraudulent or unlawful act or deed  
771 by applicants for medical assistance or other benefits, or  
772 payments made to any person, firm or corporation under the terms,  
773 conditions and authority of this article, to suspend or disqualify  
774 any provider of services, applicant or recipient for gross abuse,  
775 fraudulent or unlawful acts for such periods, including  
776 permanently, and under such conditions as the division may deem  
777 proper and just, including the imposition of a legal rate of  
778 interest on the amount improperly or incorrectly paid. Recipients  
779 who are found to have misused or abused medical assistance  
780 benefits may be locked into one (1) physician and/or one (1)  
781 pharmacy of the recipient's choice for a reasonable amount of time  
782 in order to educate and promote appropriate use of medical  
783 services, in accordance with federal regulations. Should an  
784 administrative hearing become necessary, the division shall be  
785 authorized, should the provider not succeed in his defense, in  
786 taxing the costs of the administrative hearing, including the  
787 costs of the court reporter or stenographer and transcript, to the  
788 provider. The convictions of a recipient or a provider in a state  
789 or federal court for abuse, fraudulent or unlawful acts under this  
790 chapter shall constitute an automatic disqualification of the  
791 recipient or automatic disqualification of the provider from  
792 participation under the Medicaid program.





793 A conviction, for the purposes of this chapter, shall include  
794 a judgment entered on a plea of nolo contendere or a  
795 nonadjudicated guilty plea and shall have the same force as a  
796 judgment entered pursuant to a guilty plea or a conviction  
797 following trial. A certified copy of the judgment of the court of  
798 competent jurisdiction of such conviction shall constitute prima  
799 facie evidence of such conviction for disqualification purposes;

800 (m) Establish and provide such methods of  
801 administration as may be necessary for the proper and efficient  
802 operation of the program, fully utilizing computer equipment as  
803 may be necessary to oversee and control all current expenditures  
804 for purposes of this article, and to closely monitor and supervise  
805 all recipient payments and vendors rendering such services  
806 hereunder;

807 (n) To cooperate and contract with the federal  
808 government for the purpose of providing medical assistance to  
809 Vietnamese and Cambodian refugees, pursuant to the provisions of  
810 Public Law 94-23 and Public Law 94-24, including any amendments  
811 thereto, only to the extent that such assistance and the  
812 administrative cost related thereto are one hundred percent (100%)  
813 reimbursable by the federal government. For the purposes of  
814 Section 43-13-117, persons receiving medical assistance pursuant  
815 to Public Law 94-23 and Public Law 94-24, including any amendments  
816 thereto, shall not be considered a new group or category of  
817 recipient; and

818 (o) The division shall impose penalties upon Medicaid  
819 only, Title XIX participating long-term care facilities found to  
820 be in noncompliance with division and certification standards in  
821 accordance with federal and state regulations, including interest  
822 at the same rate calculated by the Department of Health and Human  
823 Services and/or the Health Care Financing Administration under  
824 federal regulations.



825           (2) The division also shall exercise such additional powers  
826 and perform such other duties as may be conferred upon the  
827 division by act of the Legislature hereafter.

828           (3) The division, and the State Department of Health as the  
829 agency for licensure of health care facilities and certification  
830 and inspection for the Medicaid and/or Medicare programs, shall  
831 contract for or otherwise provide for the consolidation of on-site  
832 inspections of health care facilities which are necessitated by  
833 the respective programs and functions of the division and the  
834 department.

835           (4) The division and its hearing officers shall have power  
836 to preserve and enforce order during hearings; to issue subpoenas  
837 for, to administer oaths to and to compel the attendance and  
838 testimony of witnesses, or the production of books, papers,  
839 documents and other evidence, or the taking of depositions before  
840 any designated individual competent to administer oaths; to  
841 examine witnesses; and to do all things conformable to law which  
842 may be necessary to enable them effectively to discharge the  
843 duties of their office. In compelling the attendance and  
844 testimony of witnesses, or the production of books, papers,  
845 documents and other evidence, or the taking of depositions, as  
846 authorized by this section, the division or its hearing officers  
847 may designate an individual employed by the division or some other  
848 suitable person to execute and return such process, whose action  
849 in executing and returning such process shall be as lawful as if  
850 done by the sheriff or some other proper officer authorized to  
851 execute and return process in the county where the witness may  
852 reside. In carrying out the investigatory powers under the  
853 provisions of this article, the director or other designated  
854 person or persons shall be authorized to examine, obtain, copy or  
855 reproduce the books, papers, documents, medical charts,  
856 prescriptions and other records relating to medical care and  
857 services furnished by the provider to a recipient or designated



858 recipients of Medicaid services under investigation. In the  
859 absence of the voluntary submission of the books, papers,  
860 documents, medical charts, prescriptions and other records, the  
861 Governor, the director, or other designated person shall be  
862 authorized to issue and serve subpoenas instantly upon such  
863 provider, his agent, servant or employee for the production of the  
864 books, papers, documents, medical charts, prescriptions or other  
865 records during an audit or investigation of the provider. If any  
866 provider or his agent, servant or employee should refuse to  
867 produce the records after being duly subpoenaed, the director  
868 shall be authorized to certify such facts and institute contempt  
869 proceedings in the manner, time, and place as authorized by law  
870 for administrative proceedings. As an additional remedy, the  
871 division shall be authorized to recover all amounts paid to the  
872 provider covering the period of the audit or investigation,  
873 inclusive of a legal rate of interest and a reasonable attorney's  
874 fee and costs of court if suit becomes necessary. Division staff  
875 shall have immediate access to the provider's physical location,  
876 facilities, records, documents, books, and any other records  
877 relating to medical care and services rendered to recipients  
878 during regular business hours.

879 (5) If any person in proceedings before the division  
880 disobeys or resists any lawful order or process, or misbehaves  
881 during a hearing or so near the place thereof as to obstruct the  
882 same, or neglects to produce, after having been ordered to do so,  
883 any pertinent book, paper or document, or refuses to appear after  
884 having been subpoenaed, or upon appearing refuses to take the oath  
885 as a witness, or after having taken the oath refuses to be  
886 examined according to law, the director shall certify the facts to  
887 any court having jurisdiction in the place in which it is sitting,  
888 and the court shall thereupon, in a summary manner, hear the  
889 evidence as to the acts complained of, and if the evidence so  
890 warrants, punish such person in the same manner and to the same



891 extent as for a contempt committed before the court, or commit  
892 such person upon the same condition as if the doing of the  
893 forbidden act had occurred with reference to the process of, or in  
894 the presence of, the court.

895 (6) In suspending or terminating any provider from  
896 participation in the Medicaid program, the division shall preclude  
897 such provider from submitting claims for payment, either  
898 personally or through any clinic, group, corporation or other  
899 association to the division or its fiscal agents for any services  
900 or supplies provided under the Medicaid program except for those  
901 services or supplies provided prior to the suspension or  
902 termination. No clinic, group, corporation or other association  
903 which is a provider of services shall submit claims for payment to  
904 the division or its fiscal agents for any services or supplies  
905 provided by a person within such organization who has been  
906 suspended or terminated from participation in the Medicaid program  
907 except for those services or supplies provided prior to the  
908 suspension or termination. When this provision is violated by a  
909 provider of services which is a clinic, group, corporation or  
910 other association, the division may suspend or terminate such  
911 organization from participation. Suspension may be applied by the  
912 division to all known affiliates of a provider, provided that each  
913 decision to include an affiliate is made on a case-by-case basis  
914 after giving due regard to all relevant facts and circumstances.  
915 The violation, failure, or inadequacy of performance may be  
916 imputed to a person with whom the provider is affiliated where  
917 such conduct was accomplished with the course of his official duty  
918 or was effectuated by him with the knowledge or approval of such  
919 person.

920 (7) The division may deny or revoke enrollment in the  
921 Medicaid program to a provider if any of the following are found  
922 to be applicable to the provider, his agent, a managing employee,



923 or any person having an ownership interest equal to five percent  
924 (5%) or greater in the provider:

925 (a) Failure to truthfully or fully disclose any and all  
926 information required, or the concealment of any and all  
927 information required, on a claim, a provider application or a  
928 provider agreement or the making of a false or misleading  
929 statement to the division relative to the Medicaid program.

930 (b) Previous or current exclusion, suspension,  
931 termination from or the involuntary withdrawing from participation  
932 in, the Medicaid program, any other state's Medicaid program,  
933 Medicare or any other public or private health or health insurance  
934 program. If the division ascertains that a provider has been  
935 convicted of a felony under federal or state law for an offense  
936 which the division determines is detrimental to the best interest  
937 of the program or of Medicaid beneficiaries, the division may  
938 refuse to enter into an agreement with such provider, or may  
939 terminate or refuse to renew an existing agreement.

940 (c) Conviction under federal or state law of a criminal  
941 offense relating to the delivery of any goods, services or  
942 supplies, including the performance of management or  
943 administrative services relating to the delivery of the goods,  
944 services or supplies, under the Medicaid program, any other  
945 state's Medicaid program, Medicare or any other public or private  
946 health or health insurance program.

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

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

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



956           (g) Conviction under federal or state law of a criminal  
957 offense punishable by imprisonment of a year or more which  
958 involves moral turpitude, or acts against the elderly, children or  
959 infirm.

960           (h) Conviction under federal or state law of a criminal  
961 offense in connection with the interference or obstruction of any  
962 investigation into any criminal offense listed in paragraphs (c)  
963 through (i) of this subsection.

964           (i) Sanction pursuant to a violation of federal or  
965 state laws or rules relative to the Medicaid program, any other  
966 state's Medicaid program, Medicare or any other public health care  
967 or health insurance program.

968           (j) Violation of licensing or certification conditions  
969 or professional standards relating to the licenses or  
970 certification of providers or the required quality of goods,  
971 services or supplies provided.

972           (k) Failure to pay recovery properly assessed or  
973 pursuant to an approved repayment schedule under the Medicaid  
974 program.

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

976           **SECTION 4.** Section 43-13-123, Mississippi Code of 1972, is  
977 amended as follows:

978           43-13-123. The determination of the method of providing  
979 payment of claims under this article shall be made by the  
980 division, with approval of the Governor, which methods may be:

981           (1) By contract with insurance companies licensed to do  
982 business in the State of Mississippi or with nonprofit hospital  
983 service corporations, medical or dental service corporations,  
984 authorized to do business in Mississippi to underwrite on an  
985 insured premium approach, such medical assistance benefits as may  
986 be available, and any carrier selected pursuant to the provisions  
987 of this article is hereby expressly authorized and empowered to  
988 undertake the performance of the requirements of such contract.



989           (2) By contract with an insurance company licensed to  
990 do business in the State of Mississippi or with nonprofit hospital  
991 service, medical or dental service organizations, or other  
992 organizations including data processing companies, authorized to  
993 do business in Mississippi to act as fiscal agent.

994           The division shall obtain services to be provided under  
995 either of the above-described provisions pursuant to the Personal  
996 Service Contract Review Board Procurement Regulations. \* \* \*

997           The authorization of the foregoing methods shall not preclude  
998 other methods of providing payment of claims through direct  
999 operation of the program by the state or its agencies.

1000           **SECTION 5.** Section 43-13-145, Mississippi Code of 1972, is  
1001 amended as follows:

1002           43-13-145. (1) Upon each nursing facility licensed or  
1003 certified by the State of Mississippi and each intermediate care  
1004 facility for the mentally retarded licensed by the State of  
1005 Mississippi, there is levied an assessment in an amount set by the  
1006 division not exceeding Two Dollars (\$2.00) per day, or fraction  
1007 thereof, for each \* \* \* licensed or certified bed of the facility.  
1008 The division may apply for a waiver from the U.S. Secretary of  
1009 Health and Human Services to exempt nonprofit, public, charitable  
1010 or religious facilities from the assessment levied under this  
1011 subsection, and if a waiver is granted, such facilities shall be  
1012 exempt from any assessment levied under this subsection after the  
1013 date that the division receives notice that the waiver has been  
1014 granted.

1015           (2) The assessment levied under this section shall be  
1016 collected by the division each quarter beginning on July 1, 1992,  
1017 and shall be based on data for the quarter ending three (3) months  
1018 before the date the assessments are to be collected.

1019           (3) All assessments collected under this section shall be  
1020 deposited in the Medical Care Fund created by Section 43-13-143.



1021 (4) The assessment levied under this section shall be in  
1022 addition to any other assessments, taxes or fees levied by law.

1023 (5) The assessment levied under this section shall  
1024 constitute a debt due the State of Mississippi from the time the  
1025 assessment is due until it is paid. If any facility liable for  
1026 payment of such assessment does not pay the assessment when it is  
1027 due, the division shall give written notice to the facility  
1028 demanding payment of the assessment within ten (10) days from the  
1029 date of delivery of the notice. Such notice shall be sent by  
1030 certified or registered mail or delivered to the facility by an  
1031 agent of the division. If any facility liable for the assessment  
1032 fails or refuses to pay it after receiving the notice and demand,  
1033 the division may withhold the Medicaid reimbursement payments that  
1034 are otherwise scheduled to be made to the facility from the time  
1035 the assessment is due until it is paid by the facility.

1036 **SECTION 6.** Section 41-7-191, Mississippi Code of 1972, is  
1037 amended as follows:

1038 41-7-191. (1) No person shall engage in any of the  
1039 following activities without obtaining the required certificate of  
1040 need:

1041 (a) The construction, development or other  
1042 establishment of a new health care facility;

1043 (b) The relocation of a health care facility or portion  
1044 thereof, or major medical equipment, unless such relocation of a  
1045 health care facility or portion thereof, or major medical  
1046 equipment, which does not involve a capital expenditure by or on  
1047 behalf of a health care facility, is within five thousand two  
1048 hundred eighty (5,280) feet from the main entrance of the health  
1049 care facility;

1050 (c) A change over a period of two (2) years' time, as  
1051 established by the State Department of Health, in existing bed  
1052 complement through the addition of more than ten (10) beds or more  
1053 than ten percent (10%) of the total bed capacity of a designated





1054 licensed category or subcategory of any health care facility,  
1055 whichever is less, from one physical facility or site to another;  
1056 the conversion over a period of two (2) years' time, as  
1057 established by the State Department of Health, of existing bed  
1058 complement of more than ten (10) beds or more than ten percent  
1059 (10%) of the total bed capacity of a designated licensed category  
1060 or subcategory of any such health care facility, whichever is  
1061 less; or the alteration, modernizing or refurbishing of any unit  
1062 or department wherein such beds may be located; provided, however,  
1063 that from and after July 1, 1994, no health care facility shall be  
1064 authorized to add any beds or convert any beds to another category  
1065 of beds without a certificate of need under the authority of  
1066 subsection (1)(c) of this section unless there is a projected need  
1067 for such beds in the planning district in which the facility is  
1068 located, as reported in the most current State Health Plan;

1069 (d) Offering of the following health services if those  
1070 services have not been provided on a regular basis by the proposed  
1071 provider of such services within the period of twelve (12) months  
1072 prior to the time such services would be offered:

- 1073 (i) Open heart surgery services;
- 1074 (ii) Cardiac catheterization services;
- 1075 (iii) Comprehensive inpatient rehabilitation  
1076 services;
- 1077 (iv) Licensed psychiatric services;
- 1078 (v) Licensed chemical dependency services;
- 1079 (vi) Radiation therapy services;
- 1080 (vii) Diagnostic imaging services of an invasive  
1081 nature, i.e. invasive digital angiography;
- 1082 (viii) Nursing home care as defined in  
1083 subparagraphs (iv), (vi) and (viii) of Section 41-7-173(h);
- 1084 (ix) Home health services;
- 1085 (x) Swing-bed services;
- 1086 (xi) Ambulatory surgical services;



1087                   (xii) Magnetic resonance imaging services;  
1088                   (xiii) Extracorporeal shock wave lithotripsy  
1089 services;  
1090                   (xiv) Long-term care hospital services;  
1091                   (xv) Positron Emission Tomography (PET) services;  
1092           (e) The relocation of one or more health services from  
1093 one physical facility or site to another physical facility or  
1094 site, unless such relocation, which does not involve a capital  
1095 expenditure by or on behalf of a health care facility, (i) is to a  
1096 physical facility or site within one thousand three hundred twenty  
1097 (1,320) feet from the main entrance of the health care facility  
1098 where the health care service is located, or (ii) is the result of  
1099 an order of a court of appropriate jurisdiction or a result of  
1100 pending litigation in such court, or by order of the State  
1101 Department of Health, or by order of any other agency or legal  
1102 entity of the state, the federal government, or any political  
1103 subdivision of either, whose order is also approved by the State  
1104 Department of Health;  
1105           (f) The acquisition or otherwise control of any major  
1106 medical equipment for the provision of medical services; provided,  
1107 however, (i) the acquisition of any major medical equipment used  
1108 only for research purposes, and (ii) the acquisition of major  
1109 medical equipment to replace medical equipment for which a  
1110 facility is already providing medical services and for which the  
1111 State Department of Health has been notified before the date of  
1112 such acquisition shall be exempt from this paragraph; an  
1113 acquisition for less than fair market value must be reviewed, if  
1114 the acquisition at fair market value would be subject to review;  
1115           (g) Changes of ownership of existing health care  
1116 facilities in which a notice of intent is not filed with the State  
1117 Department of Health at least thirty (30) days prior to the date  
1118 such change of ownership occurs, or a change in services or bed  
1119 capacity as prescribed in paragraph (c) or (d) of this subsection



1120 as a result of the change of ownership; an acquisition for less  
1121 than fair market value must be reviewed, if the acquisition at  
1122 fair market value would be subject to review;

1123 (h) The change of ownership of any health care facility  
1124 defined in subparagraphs (iv), (vi) and (viii) of Section  
1125 41-7-173(h), in which a notice of intent as described in paragraph  
1126 (g) has not been filed and if the Executive Director, Division of  
1127 Medicaid, Office of the Governor, has not certified in writing  
1128 that there will be no increase in allowable costs to Medicaid from  
1129 revaluation of the assets or from increased interest and  
1130 depreciation as a result of the proposed change of ownership;

1131 (i) Any activity described in paragraphs (a) through  
1132 (h) if undertaken by any person if that same activity would  
1133 require certificate of need approval if undertaken by a health  
1134 care facility;

1135 (j) Any capital expenditure or deferred capital  
1136 expenditure by or on behalf of a health care facility not covered  
1137 by paragraphs (a) through (h);

1138 (k) The contracting of a health care facility as  
1139 defined in subparagraphs (i) through (viii) of Section 41-7-173(h)  
1140 to establish a home office, subunit, or branch office in the space  
1141 operated as a health care facility through a formal arrangement  
1142 with an existing health care facility as defined in subparagraph  
1143 (ix) of Section 41-7-173(h).

1144 (2) The State Department of Health shall not grant approval  
1145 for or issue a certificate of need to any person proposing the new  
1146 construction of, addition to, or expansion of any health care  
1147 facility defined in subparagraphs (iv) (skilled nursing facility)  
1148 and (vi) (intermediate care facility) of Section 41-7-173(h) or  
1149 the conversion of vacant hospital beds to provide skilled or  
1150 intermediate nursing home care, except as hereinafter authorized:

1151 (a) The department may issue a certificate of need to  
1152 any person proposing the new construction of any health care



1153 facility defined in subparagraphs (iv) and (vi) of Section  
1154 41-7-173(h) as part of a life care retirement facility, in any  
1155 county bordering on the Gulf of Mexico in which is located a  
1156 National Aeronautics and Space Administration facility, not to  
1157 exceed forty (40) beds. From and after July 1, 1999, there shall  
1158 be no prohibition or restrictions on participation in the Medicaid  
1159 program (Section 43-13-101 et seq.) for the beds in the health  
1160 care facility that were authorized under this paragraph (a).

1161 (b) The department may issue certificates of need in  
1162 Harrison County to provide skilled nursing home care for  
1163 Alzheimer's Disease patients and other patients, not to exceed one  
1164 hundred fifty (150) beds. From and after July 1, 1999, there  
1165 shall be no prohibition or restrictions on participation in the  
1166 Medicaid program (Section 43-13-101 et seq.) for the beds in the  
1167 nursing facilities that were authorized under this paragraph (b).

1168 (c) The department may issue a certificate of need for  
1169 the addition to or expansion of any skilled nursing facility that  
1170 is part of an existing continuing care retirement community  
1171 located in Madison County, provided that the recipient of the  
1172 certificate of need agrees in writing that the skilled nursing  
1173 facility will not at any time participate in the Medicaid program  
1174 (Section 43-13-101 et seq.) or admit or keep any patients in the  
1175 skilled nursing facility who are participating in the Medicaid  
1176 program. This written agreement by the recipient of the  
1177 certificate of need shall be fully binding on any subsequent owner  
1178 of the skilled nursing facility, if the ownership of the facility  
1179 is transferred at any time after the issuance of the certificate  
1180 of need. Agreement that the skilled nursing facility will not  
1181 participate in the Medicaid program shall be a condition of the  
1182 issuance of a certificate of need to any person under this  
1183 paragraph (c), and if such skilled nursing facility at any time  
1184 after the issuance of the certificate of need, regardless of the  
1185 ownership of the facility, participates in the Medicaid program or



1186 admits or keeps any patients in the facility who are participating  
1187 in the Medicaid program, the State Department of Health shall  
1188 revoke the certificate of need, if it is still outstanding, and  
1189 shall deny or revoke the license of the skilled nursing facility,  
1190 at the time that the department determines, after a hearing  
1191 complying with due process, that the facility has failed to comply  
1192 with any of the conditions upon which the certificate of need was  
1193 issued, as provided in this paragraph and in the written agreement  
1194 by the recipient of the certificate of need. The total number of  
1195 beds that may be authorized under the authority of this paragraph  
1196 (c) shall not exceed sixty (60) beds.

1197 (d) The State Department of Health may issue a  
1198 certificate of need to any hospital located in DeSoto County for  
1199 the new construction of a skilled nursing facility, not to exceed  
1200 one hundred twenty (120) beds, in DeSoto County. From and after  
1201 July 1, 1999, there shall be no prohibition or restrictions on  
1202 participation in the Medicaid program (Section 43-13-101 et seq.)  
1203 for the beds in the nursing facility that were authorized under  
1204 this paragraph (d).

1205 (e) The State Department of Health may issue a  
1206 certificate of need for the construction of a nursing facility or  
1207 the conversion of beds to nursing facility beds at a personal care  
1208 facility for the elderly in Lowndes County that is owned and  
1209 operated by a Mississippi nonprofit corporation, not to exceed  
1210 sixty (60) beds. From and after July 1, 1999, there shall be no  
1211 prohibition or restrictions on participation in the Medicaid  
1212 program (Section 43-13-101 et seq.) for the beds in the nursing  
1213 facility that were authorized under this paragraph (e).

1214 (f) The State Department of Health may issue a  
1215 certificate of need for conversion of a county hospital facility  
1216 in Itawamba County to a nursing facility, not to exceed sixty (60)  
1217 beds, including any necessary construction, renovation or  
1218 expansion. From and after July 1, 1999, there shall be no



1219 prohibition or restrictions on participation in the Medicaid  
1220 program (Section 43-13-101 et seq.) for the beds in the nursing  
1221 facility that were authorized under this paragraph (f).

1222 (g) The State Department of Health may issue a  
1223 certificate of need for the construction or expansion of nursing  
1224 facility beds or the conversion of other beds to nursing facility  
1225 beds in either Hinds, Madison or Rankin Counties, not to exceed  
1226 sixty (60) beds. From and after July 1, 1999, there shall be no  
1227 prohibition or restrictions on participation in the Medicaid  
1228 program (Section 43-13-101 et seq.) for the beds in the nursing  
1229 facility that were authorized under this paragraph (g).

1230 (h) The State Department of Health may issue a  
1231 certificate of need for the construction or expansion of nursing  
1232 facility beds or the conversion of other beds to nursing facility  
1233 beds in either Hancock, Harrison or Jackson Counties, not to  
1234 exceed sixty (60) beds. From and after July 1, 1999, there shall  
1235 be no prohibition or restrictions on participation in the Medicaid  
1236 program (Section 43-13-101 et seq.) for the beds in the facility  
1237 that were authorized under this paragraph (h).

1238 (i) The department may issue a certificate of need for  
1239 the new construction of a skilled nursing facility in Leake  
1240 County, provided that the recipient of the certificate of need  
1241 agrees in writing that the skilled nursing facility will not at  
1242 any time participate in the Medicaid program (Section 43-13-101 et  
1243 seq.) or admit or keep any patients in the skilled nursing  
1244 facility who are participating in the Medicaid program. This  
1245 written agreement by the recipient of the certificate of need  
1246 shall be fully binding on any subsequent owner of the skilled  
1247 nursing facility, if the ownership of the facility is transferred  
1248 at any time after the issuance of the certificate of need.  
1249 Agreement that the skilled nursing facility will not participate  
1250 in the Medicaid program shall be a condition of the issuance of a  
1251 certificate of need to any person under this paragraph (i), and if



1252 such skilled nursing facility at any time after the issuance of  
1253 the certificate of need, regardless of the ownership of the  
1254 facility, participates in the Medicaid program or admits or keeps  
1255 any patients in the facility who are participating in the Medicaid  
1256 program, the State Department of Health shall revoke the  
1257 certificate of need, if it is still outstanding, and shall deny or  
1258 revoke the license of the skilled nursing facility, at the time  
1259 that the department determines, after a hearing complying with due  
1260 process, that the facility has failed to comply with any of the  
1261 conditions upon which the certificate of need was issued, as  
1262 provided in this paragraph and in the written agreement by the  
1263 recipient of the certificate of need. The provision of Section  
1264 43-7-193(1) regarding substantial compliance of the projection of  
1265 need as reported in the current State Health Plan is waived for  
1266 the purposes of this paragraph. The total number of nursing  
1267 facility beds that may be authorized by any certificate of need  
1268 issued under this paragraph (i) shall not exceed sixty (60) beds.  
1269 If the skilled nursing facility authorized by the certificate of  
1270 need issued under this paragraph is not constructed and fully  
1271 operational within eighteen (18) months after July 1, 1994, the  
1272 State Department of Health, after a hearing complying with due  
1273 process, shall revoke the certificate of need, if it is still  
1274 outstanding, and shall not issue a license for the skilled nursing  
1275 facility at any time after the expiration of the eighteen-month  
1276 period.

1277 (j) The department may issue certificates of need to  
1278 allow any existing freestanding long-term care facility in  
1279 Tishomingo County and Hancock County that on July 1, 1995, is  
1280 licensed with fewer than sixty (60) beds. For the purposes of  
1281 this paragraph (j), the provision of Section 41-7-193(1) requiring  
1282 substantial compliance with the projection of need as reported in  
1283 the current State Health Plan is waived. From and after July 1,  
1284 1999, there shall be no prohibition or restrictions on



1285 participation in the Medicaid program (Section 43-13-101 et seq.)  
1286 for the beds in the long-term care facilities that were authorized  
1287 under this paragraph (j).

1288           (k) The department may issue a certificate of need for  
1289 the construction of a nursing facility at a continuing care  
1290 retirement community in Lowndes County. The total number of beds  
1291 that may be authorized under the authority of this paragraph (k)  
1292 shall not exceed sixty (60) beds. From and after July 1, 2001,  
1293 the prohibition on the facility participating in the Medicaid  
1294 program (Section 43-13-101 et seq.) that was a condition of  
1295 issuance of the certificate of need under this paragraph (k) shall  
1296 be revised as follows: The nursing facility may participate in  
1297 the Medicaid program from and after July 1, 2001, if the owner of  
1298 the facility on July 1, 2001, agrees in writing that no more than  
1299 thirty (30) of the beds at the facility will be certified for  
1300 participation in the Medicaid program, and that no claim will be  
1301 submitted for Medicaid reimbursement for more than thirty (30)  
1302 patients in the facility in any month or for any patient in the  
1303 facility who is in a bed that is not Medicaid-certified. This  
1304 written agreement by the owner of the facility shall be a  
1305 condition of licensure of the facility, and the agreement shall be  
1306 fully binding on any subsequent owner of the facility if the  
1307 ownership of the facility is transferred at any time after July 1,  
1308 2001. After this written agreement is executed, the Division of  
1309 Medicaid and the State Department of Health shall not certify more  
1310 than thirty (30) of the beds in the facility for participation in  
1311 the Medicaid program. If the facility violates the terms of the  
1312 written agreement by admitting or keeping in the facility on a  
1313 regular or continuing basis more than thirty (30) patients who are  
1314 participating in the Medicaid program, the State Department of  
1315 Health shall revoke the license of the facility, at the time that  
1316 the department determines, after a hearing complying with due  
1317 process, that the facility has violated the written agreement.





1318           (1) Provided that funds are specifically appropriated  
1319 therefor by the Legislature, the department may issue a  
1320 certificate of need to a rehabilitation hospital in Hinds County  
1321 for the construction of a sixty-bed long-term care nursing  
1322 facility dedicated to the care and treatment of persons with  
1323 severe disabilities including persons with spinal cord and  
1324 closed-head injuries and ventilator-dependent patients. The  
1325 provision of Section 41-7-193(1) regarding substantial compliance  
1326 with projection of need as reported in the current State Health  
1327 Plan is hereby waived for the purpose of this paragraph.

1328           (m) The State Department of Health may issue a  
1329 certificate of need to a county-owned hospital in the Second  
1330 Judicial District of Panola County for the conversion of not more  
1331 than seventy-two (72) hospital beds to nursing facility beds,  
1332 provided that the recipient of the certificate of need agrees in  
1333 writing that none of the beds at the nursing facility will be  
1334 certified for participation in the Medicaid program (Section  
1335 43-13-101 et seq.), and that no claim will be submitted for  
1336 Medicaid reimbursement in the nursing facility in any day or for  
1337 any patient in the nursing facility. This written agreement by  
1338 the recipient of the certificate of need shall be a condition of  
1339 the issuance of the certificate of need under this paragraph, and  
1340 the agreement shall be fully binding on any subsequent owner of  
1341 the nursing facility if the ownership of the nursing facility is  
1342 transferred at any time after the issuance of the certificate of  
1343 need. After this written agreement is executed, the Division of  
1344 Medicaid and the State Department of Health shall not certify any  
1345 of the beds in the nursing facility for participation in the  
1346 Medicaid program. If the nursing facility violates the terms of  
1347 the written agreement by admitting or keeping in the nursing  
1348 facility on a regular or continuing basis any patients who are  
1349 participating in the Medicaid program, the State Department of  
1350 Health shall revoke the license of the nursing facility, at the



1351 time that the department determines, after a hearing complying  
1352 with due process, that the nursing facility has violated the  
1353 condition upon which the certificate of need was issued, as  
1354 provided in this paragraph and in the written agreement. If the  
1355 certificate of need authorized under this paragraph is not issued  
1356 within twelve (12) months after July 1, 2001, the department shall  
1357 deny the application for the certificate of need and shall not  
1358 issue the certificate of need at any time after the twelve-month  
1359 period, unless the issuance is contested. If the certificate of  
1360 need is issued and substantial construction of the nursing  
1361 facility beds has not commenced within eighteen (18) months after  
1362 July 1, 2001, the State Department of Health, after a hearing  
1363 complying with due process, shall revoke the certificate of need  
1364 if it is still outstanding, and the department shall not issue a  
1365 license for the nursing facility at any time after the  
1366 eighteen-month period. Provided, however, that if the issuance of  
1367 the certificate of need is contested, the department shall require  
1368 substantial construction of the nursing facility beds within six  
1369 (6) months after final adjudication on the issuance of the  
1370 certificate of need.

1371 (n) The department may issue a certificate of need for  
1372 the new construction, addition or conversion of skilled nursing  
1373 facility beds in Madison County, provided that the recipient of  
1374 the certificate of need agrees in writing that the skilled nursing  
1375 facility will not at any time participate in the Medicaid program  
1376 (Section 43-13-101 et seq.) or admit or keep any patients in the  
1377 skilled nursing facility who are participating in the Medicaid  
1378 program. This written agreement by the recipient of the  
1379 certificate of need shall be fully binding on any subsequent owner  
1380 of the skilled nursing facility, if the ownership of the facility  
1381 is transferred at any time after the issuance of the certificate  
1382 of need. Agreement that the skilled nursing facility will not  
1383 participate in the Medicaid program shall be a condition of the



1384 issuance of a certificate of need to any person under this  
1385 paragraph (n), and if such skilled nursing facility at any time  
1386 after the issuance of the certificate of need, regardless of the  
1387 ownership of the facility, participates in the Medicaid program or  
1388 admits or keeps any patients in the facility who are participating  
1389 in the Medicaid program, the State Department of Health shall  
1390 revoke the certificate of need, if it is still outstanding, and  
1391 shall deny or revoke the license of the skilled nursing facility,  
1392 at the time that the department determines, after a hearing  
1393 complying with due process, that the facility has failed to comply  
1394 with any of the conditions upon which the certificate of need was  
1395 issued, as provided in this paragraph and in the written agreement  
1396 by the recipient of the certificate of need. The total number of  
1397 nursing facility beds that may be authorized by any certificate of  
1398 need issued under this paragraph (n) shall not exceed sixty (60)  
1399 beds. If the certificate of need authorized under this paragraph  
1400 is not issued within twelve (12) months after July 1, 1998, the  
1401 department shall deny the application for the certificate of need  
1402 and shall not issue the certificate of need at any time after the  
1403 twelve-month period, unless the issuance is contested. If the  
1404 certificate of need is issued and substantial construction of the  
1405 nursing facility beds has not commenced within eighteen (18)  
1406 months after the effective date of July 1, 1998, the State  
1407 Department of Health, after a hearing complying with due process,  
1408 shall revoke the certificate of need if it is still outstanding,  
1409 and the department shall not issue a license for the nursing  
1410 facility at any time after the eighteen-month period. Provided,  
1411 however, that if the issuance of the certificate of need is  
1412 contested, the department shall require substantial construction  
1413 of the nursing facility beds within six (6) months after final  
1414 adjudication on the issuance of the certificate of need.

1415 (o) The department may issue a certificate of need for  
1416 the new construction, addition or conversion of skilled nursing



1417 facility beds in Leake County, provided that the recipient of the  
1418 certificate of need agrees in writing that the skilled nursing  
1419 facility will not at any time participate in the Medicaid program  
1420 (Section 43-13-101 et seq.) or admit or keep any patients in the  
1421 skilled nursing facility who are participating in the Medicaid  
1422 program. This written agreement by the recipient of the  
1423 certificate of need shall be fully binding on any subsequent owner  
1424 of the skilled nursing facility, if the ownership of the facility  
1425 is transferred at any time after the issuance of the certificate  
1426 of need. Agreement that the skilled nursing facility will not  
1427 participate in the Medicaid program shall be a condition of the  
1428 issuance of a certificate of need to any person under this  
1429 paragraph (o), and if such skilled nursing facility at any time  
1430 after the issuance of the certificate of need, regardless of the  
1431 ownership of the facility, participates in the Medicaid program or  
1432 admits or keeps any patients in the facility who are participating  
1433 in the Medicaid program, the State Department of Health shall  
1434 revoke the certificate of need, if it is still outstanding, and  
1435 shall deny or revoke the license of the skilled nursing facility,  
1436 at the time that the department determines, after a hearing  
1437 complying with due process, that the facility has failed to comply  
1438 with any of the conditions upon which the certificate of need was  
1439 issued, as provided in this paragraph and in the written agreement  
1440 by the recipient of the certificate of need. The total number of  
1441 nursing facility beds that may be authorized by any certificate of  
1442 need issued under this paragraph (o) shall not exceed sixty (60)  
1443 beds. If the certificate of need authorized under this paragraph  
1444 is not issued within twelve (12) months after July 1, 2001, the  
1445 department shall deny the application for the certificate of need  
1446 and shall not issue the certificate of need at any time after the  
1447 twelve-month period, unless the issuance is contested. If the  
1448 certificate of need is issued and substantial construction of the  
1449 nursing facility beds has not commenced within eighteen (18)



1450 months after the effective date of July 1, 2001, the State  
1451 Department of Health, after a hearing complying with due process,  
1452 shall revoke the certificate of need if it is still outstanding,  
1453 and the department shall not issue a license for the nursing  
1454 facility at any time after the eighteen-month period. Provided,  
1455 however, that if the issuance of the certificate of need is  
1456 contested, the department shall require substantial construction  
1457 of the nursing facility beds within six (6) months after final  
1458 adjudication on the issuance of the certificate of need.

1459           (p) The department may issue a certificate of need for  
1460 the construction of a municipally-owned nursing facility within  
1461 the Town of Belmont in Tishomingo County, not to exceed sixty (60)  
1462 beds, provided that the recipient of the certificate of need  
1463 agrees in writing that the skilled nursing facility will not at  
1464 any time participate in the Medicaid program (Section 43-13-101 et  
1465 seq.) or admit or keep any patients in the skilled nursing  
1466 facility who are participating in the Medicaid program. This  
1467 written agreement by the recipient of the certificate of need  
1468 shall be fully binding on any subsequent owner of the skilled  
1469 nursing facility, if the ownership of the facility is transferred  
1470 at any time after the issuance of the certificate of need.

1471 Agreement that the skilled nursing facility will not participate  
1472 in the Medicaid program shall be a condition of the issuance of a  
1473 certificate of need to any person under this paragraph (p), and if  
1474 such skilled nursing facility at any time after the issuance of  
1475 the certificate of need, regardless of the ownership of the  
1476 facility, participates in the Medicaid program or admits or keeps  
1477 any patients in the facility who are participating in the Medicaid  
1478 program, the State Department of Health shall revoke the  
1479 certificate of need, if it is still outstanding, and shall deny or  
1480 revoke the license of the skilled nursing facility, at the time  
1481 that the department determines, after a hearing complying with due  
1482 process, that the facility has failed to comply with any of the



1483 conditions upon which the certificate of need was issued, as  
1484 provided in this paragraph and in the written agreement by the  
1485 recipient of the certificate of need. The provision of Section  
1486 43-7-193(1) regarding substantial compliance of the projection of  
1487 need as reported in the current State Health Plan is waived for  
1488 the purposes of this paragraph. If the certificate of need  
1489 authorized under this paragraph is not issued within twelve (12)  
1490 months after July 1, 1998, the department shall deny the  
1491 application for the certificate of need and shall not issue the  
1492 certificate of need at any time after the twelve-month period,  
1493 unless the issuance is contested. If the certificate of need is  
1494 issued and substantial construction of the nursing facility beds  
1495 has not commenced within eighteen (18) months after July 1, 1998,  
1496 the State Department of Health, after a hearing complying with due  
1497 process, shall revoke the certificate of need if it is still  
1498 outstanding, and the department shall not issue a license for the  
1499 nursing facility at any time after the eighteen-month period.  
1500 Provided, however, that if the issuance of the certificate of need  
1501 is contested, the department shall require substantial  
1502 construction of the nursing facility beds within six (6) months  
1503 after final adjudication on the issuance of the certificate of  
1504 need.

1505 (q) (i) Beginning on July 1, 1999, the State  
1506 Department of Health shall issue certificates of need during each  
1507 of the next four (4) fiscal years for the construction or  
1508 expansion of nursing facility beds or the conversion of other beds  
1509 to nursing facility beds in each county in the state having a need  
1510 for fifty (50) or more additional nursing facility beds, as shown  
1511 in the fiscal year 1999 State Health Plan, in the manner provided  
1512 in this paragraph (q). The total number of nursing facility beds  
1513 that may be authorized by any certificate of need authorized under  
1514 this paragraph (q) shall not exceed sixty (60) beds.



1515                   (ii) Subject to the provisions of subparagraph  
1516 (v), during each of the next four (4) fiscal years, the department  
1517 shall issue six (6) certificates of need for new nursing facility  
1518 beds, as follows: During fiscal years 2000, 2001 and 2002, one  
1519 (1) certificate of need shall be issued for new nursing facility  
1520 beds in the county in each of the four (4) Long-Term Care Planning  
1521 Districts designated in the fiscal year 1999 State Health Plan  
1522 that has the highest need in the district for those beds; and two  
1523 (2) certificates of need shall be issued for new nursing facility  
1524 beds in the two (2) counties from the state at large that have the  
1525 highest need in the state for those beds, when considering the  
1526 need on a statewide basis and without regard to the Long-Term Care  
1527 Planning Districts in which the counties are located. During  
1528 fiscal year 2003, one (1) certificate of need shall be issued for  
1529 new nursing facility beds in any county having a need for fifty  
1530 (50) or more additional nursing facility beds, as shown in the  
1531 fiscal year 1999 State Health Plan, that has not received a  
1532 certificate of need under this paragraph (q) during the three (3)  
1533 previous fiscal years. During fiscal year 2000, in addition to  
1534 the six (6) certificates of need authorized in this subparagraph,  
1535 the department also shall issue a certificate of need for new  
1536 nursing facility beds in Amite County and a certificate of need  
1537 for new nursing facility beds in Carroll County.

1538                   (iii) Subject to the provisions of subparagraph  
1539 (v), the certificate of need issued under subparagraph (ii) for  
1540 nursing facility beds in each Long-Term Care Planning District  
1541 during each fiscal year shall first be available for nursing  
1542 facility beds in the county in the district having the highest  
1543 need for those beds, as shown in the fiscal year 1999 State Health  
1544 Plan. If there are no applications for a certificate of need for  
1545 nursing facility beds in the county having the highest need for  
1546 those beds by the date specified by the department, then the  
1547 certificate of need shall be available for nursing facility beds



1548 in other counties in the district in descending order of the need  
1549 for those beds, from the county with the second highest need to  
1550 the county with the lowest need, until an application is received  
1551 for nursing facility beds in an eligible county in the district.

1552 (iv) Subject to the provisions of subparagraph  
1553 (v), the certificate of need issued under subparagraph (ii) for  
1554 nursing facility beds in the two (2) counties from the state at  
1555 large during each fiscal year shall first be available for nursing  
1556 facility beds in the two (2) counties that have the highest need  
1557 in the state for those beds, as shown in the fiscal year 1999  
1558 State Health Plan, when considering the need on a statewide basis  
1559 and without regard to the Long-Term Care Planning Districts in  
1560 which the counties are located. If there are no applications for  
1561 a certificate of need for nursing facility beds in either of the  
1562 two (2) counties having the highest need for those beds on a  
1563 statewide basis by the date specified by the department, then the  
1564 certificate of need shall be available for nursing facility beds  
1565 in other counties from the state at large in descending order of  
1566 the need for those beds on a statewide basis, from the county with  
1567 the second highest need to the county with the lowest need, until  
1568 an application is received for nursing facility beds in an  
1569 eligible county from the state at large.

1570 (v) If a certificate of need is authorized to be  
1571 issued under this paragraph (q) for nursing facility beds in a  
1572 county on the basis of the need in the Long-Term Care Planning  
1573 District during any fiscal year of the four-year period, a  
1574 certificate of need shall not also be available under this  
1575 paragraph (q) for additional nursing facility beds in that county  
1576 on the basis of the need in the state at large, and that county  
1577 shall be excluded in determining which counties have the highest  
1578 need for nursing facility beds in the state at large for that  
1579 fiscal year. After a certificate of need has been issued under  
1580 this paragraph (q) for nursing facility beds in a county during





1581 any fiscal year of the four-year period, a certificate of need  
1582 shall not be available again under this paragraph (q) for  
1583 additional nursing facility beds in that county during the  
1584 four-year period, and that county shall be excluded in determining  
1585 which counties have the highest need for nursing facility beds in  
1586 succeeding fiscal years.

1587 (vi) If more than one (1) application is made for  
1588 a certificate of need for nursing home facility beds available  
1589 under this paragraph (q), in Yalobusha, Newton or Tallahatchie  
1590 County, and one (1) of the applicants is a county-owned hospital  
1591 located in the county where the nursing facility beds are  
1592 available, the department shall give priority to the county-owned  
1593 hospital in granting the certificate of need if the following  
1594 conditions are met:

1595 1. The county-owned hospital fully meets all  
1596 applicable criteria and standards required to obtain a certificate  
1597 of need for the nursing facility beds; and

1598 2. The county-owned hospital's qualifications  
1599 for the certificate of need, as shown in its application and as  
1600 determined by the department, are at least equal to the  
1601 qualifications of the other applicants for the certificate of  
1602 need.

1603 (r) (i) Beginning on July 1, 1999, the State  
1604 Department of Health shall issue certificates of need during each  
1605 of the next two (2) fiscal years for the construction or expansion  
1606 of nursing facility beds or the conversion of other beds to  
1607 nursing facility beds in each of the four (4) Long-Term Care  
1608 Planning Districts designated in the fiscal year 1999 State Health  
1609 Plan, to provide care exclusively to patients with Alzheimer's  
1610 disease.

1611 (ii) Not more than twenty (20) beds may be  
1612 authorized by any certificate of need issued under this paragraph  
1613 (r), and not more than a total of sixty (60) beds may be



1614 authorized in any Long-Term Care Planning District by all  
1615 certificates of need issued under this paragraph (r). However,  
1616 the total number of beds that may be authorized by all  
1617 certificates of need issued under this paragraph (r) during any  
1618 fiscal year shall not exceed one hundred twenty (120) beds, and  
1619 the total number of beds that may be authorized in any Long-Term  
1620 Care Planning District during any fiscal year shall not exceed  
1621 forty (40) beds. Of the certificates of need that are issued for  
1622 each Long-Term Care Planning District during the next two (2)  
1623 fiscal years, at least one (1) shall be issued for beds in the  
1624 northern part of the district, at least one (1) shall be issued  
1625 for beds in the central part of the district, and at least one (1)  
1626 shall be issued for beds in the southern part of the district.

1627 (iii) The State Department of Health, in  
1628 consultation with the Department of Mental Health and the Division  
1629 of Medicaid, shall develop and prescribe the staffing levels,  
1630 space requirements and other standards and requirements that must  
1631 be met with regard to the nursing facility beds authorized under  
1632 this paragraph (r) to provide care exclusively to patients with  
1633 Alzheimer's disease.

1634 (3) The State Department of Health may grant approval for  
1635 and issue certificates of need to any person proposing the new  
1636 construction of, addition to, conversion of beds of or expansion  
1637 of any health care facility defined in subparagraph (x)  
1638 (psychiatric residential treatment facility) of Section  
1639 41-7-173(h). The total number of beds which may be authorized by  
1640 such certificates of need shall not exceed three hundred  
1641 thirty-four (334) beds for the entire state.

1642 (a) Of the total number of beds authorized under this  
1643 subsection, the department shall issue a certificate of need to a  
1644 privately owned psychiatric residential treatment facility in  
1645 Simpson County for the conversion of sixteen (16) intermediate  
1646 care facility for the mentally retarded (ICF-MR) beds to



1647 psychiatric residential treatment facility beds, provided that  
1648 facility agrees in writing that the facility shall give priority  
1649 for the use of those sixteen (16) beds to Mississippi residents  
1650 who are presently being treated in out-of-state facilities.

1651 (b) Of the total number of beds authorized under this  
1652 subsection, the department may issue a certificate or certificates  
1653 of need for the construction or expansion of psychiatric  
1654 residential treatment facility beds or the conversion of other  
1655 beds to psychiatric residential treatment facility beds in Warren  
1656 County, not to exceed sixty (60) psychiatric residential treatment  
1657 facility beds, provided that the facility agrees in writing that  
1658 no more than thirty (30) of the beds at the psychiatric  
1659 residential treatment facility will be certified for participation  
1660 in the Medicaid program (Section 43-13-101 et seq.) for the use of  
1661 any patients other than those who are participating only in the  
1662 Medicaid program of another state, and that no claim will be  
1663 submitted to the Division of Medicaid for Medicaid reimbursement  
1664 for more than thirty (30) patients in the psychiatric residential  
1665 treatment facility in any day or for any patient in the  
1666 psychiatric residential treatment facility who is in a bed that is  
1667 not Medicaid-certified. This written agreement by the recipient  
1668 of the certificate of need shall be a condition of the issuance of  
1669 the certificate of need under this paragraph, and the agreement  
1670 shall be fully binding on any subsequent owner of the psychiatric  
1671 residential treatment facility if the ownership of the facility is  
1672 transferred at any time after the issuance of the certificate of  
1673 need. After this written agreement is executed, the Division of  
1674 Medicaid and the State Department of Health shall not certify more  
1675 than thirty (30) of the beds in the psychiatric residential  
1676 treatment facility for participation in the Medicaid program for  
1677 the use of any patients other than those who are participating  
1678 only in the Medicaid program of another state. If the psychiatric  
1679 residential treatment facility violates the terms of the written



1680 agreement by admitting or keeping in the facility on a regular or  
1681 continuing basis more than thirty (30) patients who are  
1682 participating in the Mississippi Medicaid program, the State  
1683 Department of Health shall revoke the license of the facility, at  
1684 the time that the department determines, after a hearing complying  
1685 with due process, that the facility has violated the condition  
1686 upon which the certificate of need was issued, as provided in this  
1687 paragraph and in the written agreement.

1688         If by January 1, 2002, there has been no significant  
1689 commencement of construction of the beds authorized under this  
1690 paragraph (b), or no significant action taken to convert existing  
1691 beds to the beds authorized under this paragraph, then the  
1692 certificate of need that was previously issued under this  
1693 paragraph shall expire. If the previously issued certificate of  
1694 need expires, the department may accept applications for issuance  
1695 of another certificate of need for the beds authorized under this  
1696 paragraph, and may issue a certificate of need to authorize the  
1697 construction, expansion or conversion of the beds authorized under  
1698 this paragraph.

1699         (c) Of the total number of beds authorized under this  
1700 subsection, the department shall issue a certificate of need to a  
1701 hospital currently operating Medicaid-certified acute psychiatric  
1702 beds for adolescents in DeSoto County, for the establishment of a  
1703 forty-bed psychiatric residential treatment facility in DeSoto  
1704 County, provided that the hospital agrees in writing (i) that the  
1705 hospital shall give priority for the use of those forty (40) beds  
1706 to Mississippi residents who are presently being treated in  
1707 out-of-state facilities, and (ii) that no more than fifteen (15)  
1708 of the beds at the psychiatric residential treatment facility will  
1709 be certified for participation in the Medicaid program (Section  
1710 43-13-101 et seq.), and that no claim will be submitted for  
1711 Medicaid reimbursement for more than fifteen (15) patients in the  
1712 psychiatric residential treatment facility in any day or for any



1713 patient in the psychiatric residential treatment facility who is  
1714 in a bed that is not Medicaid-certified. This written agreement  
1715 by the recipient of the certificate of need shall be a condition  
1716 of the issuance of the certificate of need under this paragraph,  
1717 and the agreement shall be fully binding on any subsequent owner  
1718 of the psychiatric residential treatment facility if the ownership  
1719 of the facility is transferred at any time after the issuance of  
1720 the certificate of need. After this written agreement is  
1721 executed, the Division of Medicaid and the State Department of  
1722 Health shall not certify more than fifteen (15) of the beds in the  
1723 psychiatric residential treatment facility for participation in  
1724 the Medicaid program. If the psychiatric residential treatment  
1725 facility violates the terms of the written agreement by admitting  
1726 or keeping in the facility on a regular or continuing basis more  
1727 than fifteen (15) patients who are participating in the Medicaid  
1728 program, the State Department of Health shall revoke the license  
1729 of the facility, at the time that the department determines, after  
1730 a hearing complying with due process, that the facility has  
1731 violated the condition upon which the certificate of need was  
1732 issued, as provided in this paragraph and in the written  
1733 agreement.

1734 (d) Of the total number of beds authorized under this  
1735 subsection, the department may issue a certificate or certificates  
1736 of need for the construction or expansion of psychiatric  
1737 residential treatment facility beds or the conversion of other  
1738 beds to psychiatric treatment facility beds, not to exceed thirty  
1739 (30) psychiatric residential treatment facility beds, in either  
1740 Alcorn, Tishomingo, Prentiss, Lee, Itawamba, Monroe, Chickasaw,  
1741 Pontotoc, Calhoun, Lafayette, Union, Benton or Tippah Counties.

1742 (e) Of the total number of beds authorized under this  
1743 subsection (3) the department shall issue a certificate of need to  
1744 a privately owned, nonprofit psychiatric residential treatment  
1745 facility in Hinds County for an eight-bed expansion of the



1746 facility, provided that the facility agrees in writing that the  
1747 facility shall give priority for the use of those eight (8) beds  
1748 to Mississippi residents who are presently being treated in  
1749 out-of-state facilities.

1750 (f) The department shall issue a certificate of need to  
1751 a one-hundred-thirty-four-bed specialty hospital located on  
1752 twenty-nine and forty-four one-hundredths (29.44) commercial acres  
1753 at 5900 Highway 39 North in Meridian (Lauderdale County),  
1754 Mississippi, for the addition, construction or expansion of  
1755 child/adolescent psychiatric residential treatment facility beds  
1756 in Lauderdale County. As a condition of issuance of the  
1757 certificate of need under this paragraph, the facility shall give  
1758 priority in admissions to the child/adolescent psychiatric  
1759 residential treatment facility beds authorized under this  
1760 paragraph to patients who otherwise would require out-of-state  
1761 placement. \* \* \* For purposes of this paragraph, the provisions  
1762 of Section 41-7-193(1) requiring substantial compliance with the  
1763 projection of need as reported in the current State Health Plan  
1764 are waived. The total number of child/adolescent psychiatric  
1765 residential treatment facility beds that may be authorized under  
1766 the authority of this paragraph shall be sixty (60) beds. There  
1767 shall be no prohibition or restrictions on participation in the  
1768 Medicaid program (Section 43-13-101 et seq.) for the person  
1769 receiving the certificate of need authorized under this paragraph  
1770 or for the beds converted pursuant to the authority of that  
1771 certificate of need.

1772 (4) (a) From and after July 1, 1993, the department shall  
1773 not issue a certificate of need to any person for the new  
1774 construction of any hospital, psychiatric hospital or chemical  
1775 dependency hospital that will contain any child/adolescent  
1776 psychiatric or child/adolescent chemical dependency beds, or for  
1777 the conversion of any other health care facility to a hospital,  
1778 psychiatric hospital or chemical dependency hospital that will



1779 contain any child/adolescent psychiatric or child/adolescent  
1780 chemical dependency beds, or for the addition of any  
1781 child/adolescent psychiatric or child/adolescent chemical  
1782 dependency beds in any hospital, psychiatric hospital or chemical  
1783 dependency hospital, or for the conversion of any beds of another  
1784 category in any hospital, psychiatric hospital or chemical  
1785 dependency hospital to child/adolescent psychiatric or  
1786 child/adolescent chemical dependency beds, except as hereinafter  
1787 authorized:

1788                   (i) The department may issue certificates of need  
1789 to any person for any purpose described in this subsection,  
1790 provided that the hospital, psychiatric hospital or chemical  
1791 dependency hospital does not participate in the Medicaid program  
1792 (Section 43-13-101 et seq.) at the time of the application for the  
1793 certificate of need and the owner of the hospital, psychiatric  
1794 hospital or chemical dependency hospital agrees in writing that  
1795 the hospital, psychiatric hospital or chemical dependency hospital  
1796 will not at any time participate in the Medicaid program or admit  
1797 or keep any patients who are participating in the Medicaid program  
1798 in the hospital, psychiatric hospital or chemical dependency  
1799 hospital. This written agreement by the recipient of the  
1800 certificate of need shall be fully binding on any subsequent owner  
1801 of the hospital, psychiatric hospital or chemical dependency  
1802 hospital, if the ownership of the facility is transferred at any  
1803 time after the issuance of the certificate of need. Agreement  
1804 that the hospital, psychiatric hospital or chemical dependency  
1805 hospital will not participate in the Medicaid program shall be a  
1806 condition of the issuance of a certificate of need to any person  
1807 under this subparagraph (a)(i), and if such hospital, psychiatric  
1808 hospital or chemical dependency hospital at any time after the  
1809 issuance of the certificate of need, regardless of the ownership  
1810 of the facility, participates in the Medicaid program or admits or  
1811 keeps any patients in the hospital, psychiatric hospital or



1812 chemical dependency hospital who are participating in the Medicaid  
1813 program, the State Department of Health shall revoke the  
1814 certificate of need, if it is still outstanding, and shall deny or  
1815 revoke the license of the hospital, psychiatric hospital or  
1816 chemical dependency hospital, at the time that the department  
1817 determines, after a hearing complying with due process, that the  
1818 hospital, psychiatric hospital or chemical dependency hospital has  
1819 failed to comply with any of the conditions upon which the  
1820 certificate of need was issued, as provided in this subparagraph  
1821 and in the written agreement by the recipient of the certificate  
1822 of need.

1823           (ii) The department may issue a certificate of  
1824 need for the conversion of existing beds in a county hospital in  
1825 Choctaw County from acute care beds to child/adolescent chemical  
1826 dependency beds. For purposes of this subparagraph, the  
1827 provisions of Section 41-7-193(1) requiring substantial compliance  
1828 with the projection of need as reported in the current State  
1829 Health Plan is waived. The total number of beds that may be  
1830 authorized under authority of this subparagraph shall not exceed  
1831 twenty (20) beds. There shall be no prohibition or restrictions  
1832 on participation in the Medicaid program (Section 43-13-101 et  
1833 seq.) for the hospital receiving the certificate of need  
1834 authorized under this subparagraph (a)(ii) or for the beds  
1835 converted pursuant to the authority of that certificate of need.

1836           (iii) The department may issue a certificate or  
1837 certificates of need for the construction or expansion of  
1838 child/adolescent psychiatric beds or the conversion of other beds  
1839 to child/adolescent psychiatric beds in Warren County. For  
1840 purposes of this subparagraph, the provisions of Section  
1841 41-7-193(1) requiring substantial compliance with the projection  
1842 of need as reported in the current State Health Plan are waived.  
1843 The total number of beds that may be authorized under the  
1844 authority of this subparagraph shall not exceed twenty (20) beds.





1845 There shall be no prohibition or restrictions on participation in  
1846 the Medicaid program (Section 43-13-101 et seq.) for the person  
1847 receiving the certificate of need authorized under this  
1848 subparagraph (a)(iii) or for the beds converted pursuant to the  
1849 authority of that certificate of need.

1850 If by January 1, 2002, there has been no significant  
1851 commencement of construction of the beds authorized under this  
1852 subparagraph (a)(iii), or no significant action taken to convert  
1853 existing beds to the beds authorized under this subparagraph, then  
1854 the certificate of need that was previously issued under this  
1855 subparagraph shall expire. If the previously issued certificate  
1856 of need expires, the department may accept applications for  
1857 issuance of another certificate of need for the beds authorized  
1858 under this subparagraph, and may issue a certificate of need to  
1859 authorize the construction, expansion or conversion of the beds  
1860 authorized under this subparagraph.

1861 (iv) The department shall issue a certificate of  
1862 need to the Region 7 Mental Health/Retardation Commission for the  
1863 construction or expansion of child/adolescent psychiatric beds or  
1864 the conversion of other beds to child/adolescent psychiatric beds  
1865 in any of the counties served by the commission. For purposes of  
1866 this subparagraph, the provisions of Section 41-7-193(1) requiring  
1867 substantial compliance with the projection of need as reported in  
1868 the current State Health Plan is waived. The total number of beds  
1869 that may be authorized under the authority of this subparagraph  
1870 shall not exceed twenty (20) beds. There shall be no prohibition  
1871 or restrictions on participation in the Medicaid program (Section  
1872 43-13-101 et seq.) for the person receiving the certificate of  
1873 need authorized under this subparagraph (a)(iv) or for the beds  
1874 converted pursuant to the authority of that certificate of need.

1875 (v) The department may issue a certificate of need  
1876 to any county hospital located in Leflore County for the  
1877 construction or expansion of adult psychiatric beds or the



1878 conversion of other beds to adult psychiatric beds, not to exceed  
1879 twenty (20) beds, provided that the recipient of the certificate  
1880 of need agrees in writing that the adult psychiatric beds will not  
1881 at any time be certified for participation in the Medicaid program  
1882 and that the hospital will not admit or keep any patients who are  
1883 participating in the Medicaid program in any of such adult  
1884 psychiatric beds. This written agreement by the recipient of the  
1885 certificate of need shall be fully binding on any subsequent owner  
1886 of the hospital if the ownership of the hospital is transferred at  
1887 any time after the issuance of the certificate of need. Agreement  
1888 that the adult psychiatric beds will not be certified for  
1889 participation in the Medicaid program shall be a condition of the  
1890 issuance of a certificate of need to any person under this  
1891 subparagraph (a)(v), and if such hospital at any time after the  
1892 issuance of the certificate of need, regardless of the ownership  
1893 of the hospital, has any of such adult psychiatric beds certified  
1894 for participation in the Medicaid program or admits or keeps any  
1895 Medicaid patients in such adult psychiatric beds, the State  
1896 Department of Health shall revoke the certificate of need, if it  
1897 is still outstanding, and shall deny or revoke the license of the  
1898 hospital at the time that the department determines, after a  
1899 hearing complying with due process, that the hospital has failed  
1900 to comply with any of the conditions upon which the certificate of  
1901 need was issued, as provided in this subparagraph and in the  
1902 written agreement by the recipient of the certificate of need.

1903                   (vi) The department may issue a certificate or  
1904 certificates of need for the expansion of child psychiatric beds  
1905 or the conversion of other beds to child psychiatric beds at the  
1906 University of Mississippi Medical Center. For purposes of this  
1907 subparagraph (a)(vi), the provision of Section 41-7-193(1)  
1908 requiring substantial compliance with the projection of need as  
1909 reported in the current State Health Plan is waived. The total  
1910 number of beds that may be authorized under the authority of this



1911 subparagraph (a)(vi) shall not exceed fifteen (15) beds. There  
1912 shall be no prohibition or restrictions on participation in the  
1913 Medicaid program (Section 43-13-101 et seq.) for the hospital  
1914 receiving the certificate of need authorized under this  
1915 subparagraph (a)(vi) or for the beds converted pursuant to the  
1916 authority of that certificate of need.

1917 (b) From and after July 1, 1990, no hospital,  
1918 psychiatric hospital or chemical dependency hospital shall be  
1919 authorized to add any child/adolescent psychiatric or  
1920 child/adolescent chemical dependency beds or convert any beds of  
1921 another category to child/adolescent psychiatric or  
1922 child/adolescent chemical dependency beds without a certificate of  
1923 need under the authority of subsection (1)(c) of this section.

1924 (5) The department may issue a certificate of need to a  
1925 county hospital in Winston County for the conversion of fifteen  
1926 (15) acute care beds to geriatric psychiatric care beds.

1927 (6) The State Department of Health shall issue a certificate  
1928 of need to a Mississippi corporation qualified to manage a  
1929 long-term care hospital as defined in Section 41-7-173(h)(xii) in  
1930 Harrison County, not to exceed eighty (80) beds, including any  
1931 necessary renovation or construction required for licensure and  
1932 certification, provided that the recipient of the certificate of  
1933 need agrees in writing that the long-term care hospital will not  
1934 at any time participate in the Medicaid program (Section 43-13-101  
1935 et seq.) or admit or keep any patients in the long-term care  
1936 hospital who are participating in the Medicaid program. This  
1937 written agreement by the recipient of the certificate of need  
1938 shall be fully binding on any subsequent owner of the long-term  
1939 care hospital, if the ownership of the facility is transferred at  
1940 any time after the issuance of the certificate of need. Agreement  
1941 that the long-term care hospital will not participate in the  
1942 Medicaid program shall be a condition of the issuance of a  
1943 certificate of need to any person under this subsection (6), and



1944 if such long-term care hospital at any time after the issuance of  
1945 the certificate of need, regardless of the ownership of the  
1946 facility, participates in the Medicaid program or admits or keeps  
1947 any patients in the facility who are participating in the Medicaid  
1948 program, the State Department of Health shall revoke the  
1949 certificate of need, if it is still outstanding, and shall deny or  
1950 revoke the license of the long-term care hospital, at the time  
1951 that the department determines, after a hearing complying with due  
1952 process, that the facility has failed to comply with any of the  
1953 conditions upon which the certificate of need was issued, as  
1954 provided in this subsection and in the written agreement by the  
1955 recipient of the certificate of need. For purposes of this  
1956 subsection, the provision of Section 41-7-193(1) requiring  
1957 substantial compliance with the projection of need as reported in  
1958 the current State Health Plan is hereby waived.

1959 (7) The State Department of Health may issue a certificate  
1960 of need to any hospital in the state to utilize a portion of its  
1961 beds for the "swing-bed" concept. Any such hospital must be in  
1962 conformance with the federal regulations regarding such swing-bed  
1963 concept at the time it submits its application for a certificate  
1964 of need to the State Department of Health, except that such  
1965 hospital may have more licensed beds or a higher average daily  
1966 census (ADC) than the maximum number specified in federal  
1967 regulations for participation in the swing-bed program. Any  
1968 hospital meeting all federal requirements for participation in the  
1969 swing-bed program which receives such certificate of need shall  
1970 render services provided under the swing-bed concept to any  
1971 patient eligible for Medicare (Title XVIII of the Social Security  
1972 Act) who is certified by a physician to be in need of such  
1973 services, and no such hospital shall permit any patient who is  
1974 eligible for both Medicaid and Medicare or eligible only for  
1975 Medicaid to stay in the swing beds of the hospital for more than  
1976 thirty (30) days per admission unless the hospital receives prior



1977 approval for such patient from the Division of Medicaid, Office of  
1978 the Governor. Any hospital having more licensed beds or a higher  
1979 average daily census (ADC) than the maximum number specified in  
1980 federal regulations for participation in the swing-bed program  
1981 which receives such certificate of need shall develop a procedure  
1982 to insure that before a patient is allowed to stay in the swing  
1983 beds of the hospital, there are no vacant nursing home beds  
1984 available for that patient located within a fifty-mile radius of  
1985 the hospital. When any such hospital has a patient staying in the  
1986 swing beds of the hospital and the hospital receives notice from a  
1987 nursing home located within such radius that there is a vacant bed  
1988 available for that patient, the hospital shall transfer the  
1989 patient to the nursing home within a reasonable time after receipt  
1990 of the notice. Any hospital which is subject to the requirements  
1991 of the two (2) preceding sentences of this subsection may be  
1992 suspended from participation in the swing-bed program for a  
1993 reasonable period of time by the State Department of Health if the  
1994 department, after a hearing complying with due process, determines  
1995 that the hospital has failed to comply with any of those  
1996 requirements.

1997 (8) The Department of Health shall not grant approval for or  
1998 issue a certificate of need to any person proposing the new  
1999 construction of, addition to or expansion of a health care  
2000 facility as defined in subparagraph (viii) of Section 41-7-173(h).

2001 (9) The Department of Health shall not grant approval for or  
2002 issue a certificate of need to any person proposing the  
2003 establishment of, or expansion of the currently approved territory  
2004 of, or the contracting to establish a home office, subunit or  
2005 branch office within the space operated as a health care facility  
2006 as defined in Section 41-7-173(h) (i) through (viii) by a health  
2007 care facility as defined in subparagraph (ix) of Section  
2008 41-7-173(h).



2009           (10) Health care facilities owned and/or operated by the  
2010 state or its agencies are exempt from the restraints in this  
2011 section against issuance of a certificate of need if such addition  
2012 or expansion consists of repairing or renovation necessary to  
2013 comply with the state licensure law. This exception shall not  
2014 apply to the new construction of any building by such state  
2015 facility. This exception shall not apply to any health care  
2016 facilities owned and/or operated by counties, municipalities,  
2017 districts, unincorporated areas, other defined persons, or any  
2018 combination thereof.

2019           (11) The new construction, renovation or expansion of or  
2020 addition to any health care facility defined in subparagraph (ii)  
2021 (psychiatric hospital), subparagraph (iv) (skilled nursing  
2022 facility), subparagraph (vi) (intermediate care facility),  
2023 subparagraph (viii) (intermediate care facility for the mentally  
2024 retarded) and subparagraph (x) (psychiatric residential treatment  
2025 facility) of Section 41-7-173(h) which is owned by the State of  
2026 Mississippi and under the direction and control of the State  
2027 Department of Mental Health, and the addition of new beds or the  
2028 conversion of beds from one category to another in any such  
2029 defined health care facility which is owned by the State of  
2030 Mississippi and under the direction and control of the State  
2031 Department of Mental Health, shall not require the issuance of a  
2032 certificate of need under Section 41-7-171 et seq.,  
2033 notwithstanding any provision in Section 41-7-171 et seq. to the  
2034 contrary.

2035           (12) The new construction, renovation or expansion of or  
2036 addition to any veterans homes or domiciliaries for eligible  
2037 veterans of the State of Mississippi as authorized under Section  
2038 35-1-19 shall not require the issuance of a certificate of need,  
2039 notwithstanding any provision in Section 41-7-171 et seq. to the  
2040 contrary.



2041           (13) The new construction of a nursing facility or nursing  
2042 facility beds or the conversion of other beds to nursing facility  
2043 beds shall not require the issuance of a certificate of need,  
2044 notwithstanding any provision in Section 41-7-171 et seq. to the  
2045 contrary, if the conditions of this subsection are met.

2046           (a) Before any construction or conversion may be  
2047 undertaken without a certificate of need, the owner of the nursing  
2048 facility, in the case of an existing facility, or the applicant to  
2049 construct a nursing facility, in the case of new construction,  
2050 first must file a written notice of intent and sign a written  
2051 agreement with the State Department of Health that the entire  
2052 nursing facility will not at any time participate in or have any  
2053 beds certified for participation in the Medicaid program (Section  
2054 43-13-101 et seq.), will not admit or keep any patients in the  
2055 nursing facility who are participating in the Medicaid program,  
2056 and will not submit any claim for Medicaid reimbursement for any  
2057 patient in the facility. This written agreement by the owner or  
2058 applicant shall be a condition of exercising the authority under  
2059 this subsection without a certificate of need, and the agreement  
2060 shall be fully binding on any subsequent owner of the nursing  
2061 facility if the ownership of the facility is transferred at any  
2062 time after the agreement is signed. After the written agreement  
2063 is signed, the Division of Medicaid and the State Department of  
2064 Health shall not certify any beds in the nursing facility for  
2065 participation in the Medicaid program. If the nursing facility  
2066 violates the terms of the written agreement by participating in  
2067 the Medicaid program, having any beds certified for participation  
2068 in the Medicaid program, admitting or keeping any patient in the  
2069 facility who is participating in the Medicaid program, or  
2070 submitting any claim for Medicaid reimbursement for any patient in  
2071 the facility, the State Department of Health shall revoke the  
2072 license of the nursing facility at the time that the department



2073 determines, after a hearing complying with due process, that the  
2074 facility has violated the terms of the written agreement.

2075 (b) For the purposes of this subsection, participation  
2076 in the Medicaid program by a nursing facility includes Medicaid  
2077 reimbursement of coinsurance and deductibles for recipients who  
2078 are qualified Medicare beneficiaries and/or those who are dually  
2079 eligible. Any nursing facility exercising the authority under  
2080 this subsection may not bill or submit a claim to the Division of  
2081 Medicaid for services to qualified Medicare beneficiaries and/or  
2082 those who are dually eligible.

2083 (c) The new construction of a nursing facility or  
2084 nursing facility beds or the conversion of other beds to nursing  
2085 facility beds described in this section must be either a part of a  
2086 completely new continuing care retirement community, as described  
2087 in the latest edition of the Mississippi State Health Plan, or an  
2088 addition to existing personal care and independent living  
2089 components, and so that the completed project will be a continuing  
2090 care retirement community, containing (i) independent living  
2091 accommodations, (ii) personal care beds, and (iii) the nursing  
2092 home facility beds. The three (3) components must be located on a  
2093 single site and be operated as one (1) inseparable facility. The  
2094 nursing facility component must contain a minimum of thirty (30)  
2095 beds. Any nursing facility beds authorized by this section will  
2096 not be counted against the bed need set forth in the State Health  
2097 Plan, as identified in Section 41-7-171, et seq.

2098 This subsection (13) shall stand repealed from and after July  
2099 1, 2005.

2100 (14) The State Department of Health shall issue a  
2101 certificate of need to any hospital which is currently licensed  
2102 for two hundred fifty (250) or more acute care beds and is located  
2103 in any general hospital service area not having a comprehensive  
2104 cancer center, for the establishment and equipping of such a  
2105 center which provides facilities and services for outpatient





2106 radiation oncology therapy, outpatient medical oncology therapy,  
2107 and appropriate support services including the provision of  
2108 radiation therapy services. The provision of Section 41-7-193(1)  
2109 regarding substantial compliance with the projection of need as  
2110 reported in the current State Health Plan is waived for the  
2111 purpose of this subsection.

2112 (15) The State Department of Health may authorize the  
2113 transfer of hospital beds, not to exceed sixty (60) beds, from the  
2114 North Panola Community Hospital to the South Panola Community  
2115 Hospital. The authorization for the transfer of those beds shall  
2116 be exempt from the certificate of need review process.

2117 (16) Nothing in this section or in any other provision of  
2118 Section 41-7-171 et seq. shall prevent any nursing facility from  
2119 designating an appropriate number of existing beds in the facility  
2120 as beds for providing care exclusively to patients with  
2121 Alzheimer's disease.

2122 **SECTION 7.** This act shall take effect and be in force from  
2123 and after its passage.

