MISSISSIPPI LEGISLATURE REGULAR SESSION 2002

By: Senator(s) Huggins

To: Public Health and Welfare; Appropriations

SENATE BILL NO. 2189

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

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

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

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

for such care and services, within the limits of state appropriations and federal matching funds:

(1) Inpatient hospital services.

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

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

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

(2) Outpatient hospital services.

<u>(a)</u> Provided that where the same services are reimbursed as clinic services, the division may revise the rate or methodology of outpatient reimbursement to maintain consistency, efficiency, economy and quality of care. The division shall develop a Medicaid-specific cost-to-charge ratio calculation from data provided by hospitals to determine an allowable rate payment for outpatient hospital services, and shall submit a report thereon to the Medical Advisory Committee on or before December 1,

1999. The committee shall make a recommendation on the specific cost-to-charge reimbursement method for outpatient hospital services to the 2000 Regular Session of the Legislature.

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

(3) Laboratory and x-ray services.

(4) Nursing facility services.

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

(b) From and after July 1, 1997, the division shall implement the integrated case-mix payment and quality monitoring system, which includes the fair rental system for property costs and in which recapture of depreciation is eliminated. The division may reduce the payment for hospital leave and therapeutic home leave days to the lower of the case-mix category as computed for the resident on leave using the assessment being utilized for payment at that point in time, or a case-mix score of 1.000 for nursing facilities, and shall compute case-mix scores of residents so that only services provided at the

nursing facility are considered in calculating a facility's per diem.

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

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

(e) The division shall develop and implement, not later than January 1, 2001, a case-mix payment add-on determined by time studies and other valid statistical data which will reimburse a nursing facility for the additional cost of caring for a resident who has a diagnosis of Alzheimer's or other related

dementia and exhibits symptoms that require special care. Any such case-mix add-on payment shall be supported by a determination of additional cost. The division shall also develop and implement as part of the fair rental reimbursement system for nursing facility beds, an Alzheimer's resident bed depreciation enhanced reimbursement system which will provide an incentive to encourage nursing facilities to convert or construct beds for residents with Alzheimer's or other related dementia.

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

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

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

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

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

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

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

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

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

(g) In addition to reimbursement methodology for nursing facility services, the division may establish a Medicare upper payment limits program for nursing facility services in accordance with applicable federal law and regulations. The division may assess each nursing facility for the sole purpose of financing the state portion of the Medicare upper payment limits program for nursing facility services based on appropriate methodology consistent with federal law and regulations. This assessment will remain in effect as long as the state participates in a Medicare upper payment limits program for nursing facility services.

(h) Effective July 1, 2003, all Title XIX nursing facilities must be Title XVIII certified in order to participate in the Medicaid program.

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

of the State Department of Human Services may enter into a cooperative agreement with the State Department of Human Services for the provision of such services using state funds which are provided from the appropriation to the Department of Human Services to obtain federal matching funds through the division.

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

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

(b) Repealed.

(8) Emergency medical transportation services. On January 1, 1994, emergency medical transportation services shall be reimbursed at seventy percent (70%) of the rate established under Medicare (Title XVIII of the Social Security Act, as amended). "Emergency medical transportation services" shall mean, but shall not be limited to, the following services by a properly permitted ambulance operated by a properly licensed provider in accordance with the Emergency Medical Services Act of 1974

(Section 41-59-1 et seq.): (i) basic life support, (ii) advanced life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids, (vi) disposable supplies, (vii) similar services.

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

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

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

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

As used in this paragraph (9), "estimated acquisition cost" means the division's best estimate of what price providers generally are paying for a drug in the package size that providers buy most frequently. Product selection shall be made in

compliance with existing state law; however, the division may reimburse as if the prescription had been filled under the generic name. The division may provide otherwise in the case of specified drugs when the consensus of competent medical advice is that trademarked drugs are substantially more effective.

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

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

(12) Intermediate care facility services.

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

the day after Christmas, Thanksgiving, the day before Thanksgiving and the day after Thanksgiving.

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

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

(14) Clinic services. Such diagnostic, preventive, therapeutic, rehabilitative or palliative services furnished to an outpatient by or under the supervision of a physician or dentist in a facility which is not a part of a hospital but which is organized and operated to provide medical care to outpatients. Clinic services shall include any services reimbursed as outpatient hospital services which may be rendered in such a facility, including those that become so after July 1, 1991. On July 1, 1999, all fees for physicians' services reimbursed under authority of this paragraph (14) shall be reimbursed at ninety percent (90%) of the rate established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act, as amended), and which shall in no event be less than seventy percent (70%) of the rate established on January 1, 1994. All fees for physicians' services that are covered by both Medicare and Medicaid shall be reimbursed at ten percent (10%) of the adjusted Medicare payment established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act, as amended), and which shall in no event be less than seventy percent (70%) of the adjusted Medicare payment established on January 1, 1994. On July 1, 1999, all fees for dentists' services reimbursed under authority of this paragraph (14) shall be increased to one hundred sixty percent (160%) of the amount of the reimbursement rate that was in effect on June 30, 1999.

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

(16) Mental health services. Approved therapeutic and case management services provided by (a) an approved regional mental health/retardation center established under Sections 41-19-31 through 41-19-39, or by another community mental health service provider meeting the requirements of the Department of Mental Health to be an approved mental health/retardation center if determined necessary by the Department of Mental Health, using state funds which are provided from the appropriation to the State Department of Mental Health and used to match federal funds under a cooperative agreement between the division and the department, or (b) a facility which is certified by the State Department of Mental Health to provide therapeutic and case management services, to be reimbursed on a fee for service basis. Any such services provided by a facility described in paragraph (b) must have the prior approval of the division to be reimbursable under this section. After June 30, 1997, mental health services provided by regional mental health/retardation centers established under

Sections 41-19-31 through 41-19-39, or by hospitals as defined in Section 41-9-3(a) and/or their subsidiaries and divisions, or by psychiatric residential treatment facilities as defined in Section 43-11-1, or by another community mental health service provider meeting the requirements of the Department of Mental Health to be an approved mental health/retardation center if determined necessary by the Department of Mental Health, shall not be included in or provided under any capitated managed care pilot program provided for under paragraph (24) of this section.

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

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

(b) The division shall establish a Medicare Upper Payment Limits Program as defined in Section 1902 (a) (30) of the federal Social Security Act and any applicable federal regulations. The division shall assess each hospital for the sole purpose of financing the state portion of the Medicare Upper

Payment Limits Program. This assessment shall be based on Medicaid utilization, or other appropriate method consistent with federal regulations, and will remain in effect as long as the state participates in the Medicare Upper Payment Limits Program. The division shall make additional reimbursement to hospitals for the Medicare Upper Payment Limits as defined in Section 1902 (a) (30) of the federal Social Security Act and any applicable federal regulations. This paragraph (b) shall stand repealed from and after July 1, 2005.

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

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

(b) Early intervention system services. The division shall cooperate with the State Department of Health, acting as lead agency, in the development and implementation of a statewide system of delivery of early intervention services, pursuant to Part C of the Individuals with Disabilities Education Act (IDEA). The State Department of Health shall certify annually in writing to the director of the division the dollar amount of state early intervention funds available which shall be utilized as a certified match for Medicaid matching funds. Those funds

then shall be used to provide expanded targeted case management services for Medicaid eligible children with special needs who are eligible for the state's early intervention system. Qualifications for persons providing service coordination shall be determined by the State Department of Health and the Division of Medicaid.

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

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

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

(23) Inpatient psychiatric services. Inpatient psychiatric services to be determined by the division for

recipients under age twenty-one (21) which are provided under the direction of a physician in an inpatient program in a licensed acute care psychiatric facility or in a licensed psychiatric residential treatment facility, before the recipient reaches age twenty-one (21) or, if the recipient was receiving the services immediately before he reached age twenty-one (21), before the earlier of the date he no longer requires the services or the date he reaches age twenty-two (22), as provided by federal regulations. Precertification of inpatient days and residential treatment days must be obtained as required by the division.

(24) Managed care services in a program to be developed by the division by a public or private provider. If managed care services are provided by the division to Medicaid recipients, and those managed care services are operated, managed and controlled by and under the authority of the division, the division shall be responsible for educating the Medicaid recipients who are participants in the managed care program regarding the manner in which the participants should seek health care under the program. Notwithstanding any other provision in this article to the contrary, the division shall establish rates of reimbursement to providers rendering care and services authorized under this paragraph (24), and may revise such rates of reimbursement without amendment to this section by the Legislature for the purpose of achieving effective and accessible health services, and for responsible containment of costs.

(25) Birthing center services.

(26) Hospice care. As used in this paragraph, the term "hospice care" means a coordinated program of active professional medical attention within the home and outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of

physical, psychological, spiritual, social and economic stresses which are experienced during the final stages of illness and during dying and bereavement and meets the Medicare requirements for participation as a hospice as provided in federal regulations.

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

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

(29) The Division of Medicaid may apply for a waiver from the Department of Health and Human Services for home- and community-based services for developmentally disabled people using state funds which are provided from the appropriation to the State Department of Mental Health and used to match federal funds under a cooperative agreement between the division and the department, provided that funds for these services are specifically appropriated to the Department of Mental Health.

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

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

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

(33) Podiatrist services.

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

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

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

(37) [Deleted]

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

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

(40) [Deleted]

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

(42) Notwithstanding any other provision in this article to the contrary, the division is hereby authorized to develop a population health management program for women and children health services through the age of two (2). This program is primarily for obstetrical care associated with low birth weight and pre-term babies. In order to effect cost savings, the division may develop a revised payment methodology which may include at-risk capitated payments.

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

(44) Nursing facility services for the severely disabled.

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

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

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

(46) The division shall make application to the federal Health Care Financing Administration for a waiver to develop and provide services for children with serious emotional disturbances as defined in Section 43-14-1(1), which may include home- and community-based services, case management services or managed care services through mental health providers certified by the Department of Mental Health. The division may implement and provide services under this waivered program only if funds for these services are specifically appropriated for this purpose by the Legislature, or if funds are voluntarily provided by affected agencies.

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

Notwithstanding any provision of this article, except as authorized in the following paragraph and in Section 43-13-139, neither (a) the limitations on quantity or frequency of use of or the fees or charges for any of the care or services available to recipients under this section, nor (b) the payments or rates of reimbursement to providers rendering care or services authorized under this section to recipients, may be increased, decreased or otherwise changed from the levels in effect on July 1, 1999, unless such is authorized by an amendment to this section by the Legislature. However, the restriction in this paragraph shall not

prevent the division from changing the payments or rates of reimbursement to providers without an amendment to this section whenever such changes are required by federal law or regulation, or whenever such changes are necessary to correct administrative errors or omissions in calculating such payments or rates of reimbursement.

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

Notwithstanding any other provision of this article, it shall be the duty of each nursing facility, intermediate care facility for the mentally retarded, psychiatric residential treatment facility, and nursing facility for the severely disabled that is participating in the medical assistance program to keep and maintain books, documents, and other records as prescribed by the

Division of Medicaid in substantiation of its cost reports for a period of three (3) years after the date of submission to the Division of Medicaid of an original cost report, or three (3) years after the date of submission to the Division of Medicaid of an amended cost report.

SECTION 2. Section 43-13-121, Mississippi Code of 1972, is amended as follows:

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

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

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

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

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

(iv) Providing for fair and impartial hearings;

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

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

(b) Receive and expend state, federal and other funds in accordance with court judgments or settlements and agreements between the State of Mississippi and the federal government, the

rules and regulations promulgated by the division, with the approval of the Governor, and within the limitations and restrictions of this article and within the limits of funds available for such purpose;

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

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

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

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

(f) Define and determine the scope, duration and amount of medical assistance which may be provided in accordance with

this article and establish priorities therefor in conformity with this article;

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

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

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

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

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

(l) Have full, complete and plenary power and authority to conduct such investigations as it may deem necessary and requisite of alleged or suspected violations or abuses of the provisions of this article or of the regulations adopted hereunder including, but not limited to, fraudulent or unlawful act or deed by applicants for medical assistance or other benefits, or payments made to any person, firm or corporation under the terms, conditions and authority of this article, to suspend or disqualify any provider of services, applicant or recipient for gross abuse, fraudulent or unlawful acts for such periods, including permanently, and under such conditions as the division may deem proper and just, including the imposition of a legal rate of interest on the amount improperly or incorrectly paid. Recipients who are found to have misused or abused medical assistance

benefits may be locked into one (1) physician and/or one (1) pharmacy of the recipient's choice for a reasonable amount of time in order to educate and promote appropriate use of medical services, in accordance with federal regulations. Should an administrative hearing become necessary, the division shall be authorized, should the provider not succeed in his defense, in taxing the costs of the administrative hearing, including the costs of the court reporter or stenographer and transcript, to the provider. The convictions of a recipient or a provider in a state or federal court for abuse, fraudulent or unlawful acts under this chapter shall constitute an automatic disqualification of the recipient or automatic disqualification of the provider from participation under the Medicaid program.

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

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

(n) To cooperate and contract with the federal government for the purpose of providing medical assistance to Vietnamese and Cambodian refugees, pursuant to the provisions of Public Law 94-23 and Public Law 94-24, including any amendments thereto, only to the extent that such assistance and the administrative cost related thereto are one hundred percent (100%)

reimbursable by the federal government. For the purposes of Section 43-13-117, persons receiving medical assistance pursuant to Public Law 94-23 and Public Law 94-24, including any amendments thereto, shall not be considered a new group or category of recipient; and

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

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

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

(4) The division and its hearing officers shall have power to preserve and enforce order during hearings; to issue subpoenas for, to administer oaths to and to compel the attendance and testimony of witnesses, or the production of books, papers, documents and other evidence, or the taking of depositions before any designated individual competent to administer oaths; to examine witnesses; and to do all things conformable to law which may be necessary to enable them effectively to discharge the duties of their office. In compelling the attendance and testimony of witnesses, or the production of books, papers, documents and other evidence, or the taking of depositions, as

authorized by this section, the division or its hearing officers may designate an individual employed by the division or some other suitable person to execute and return such process, whose action in executing and returning such process shall be as lawful as if done by the sheriff or some other proper officer authorized to execute and return process in the county where the witness may reside. In carrying out the investigatory powers under the provisions of this article, the director or other designated person or persons shall be authorized to examine, obtain, copy or reproduce the books, papers, documents, medical charts, prescriptions and other records relating to medical care and services furnished by the provider to a recipient or designated recipients of Medicaid services under investigation. In the absence of the voluntary submission of the books, papers, documents, medical charts, prescriptions and other records, the Governor, the director, or other designated person shall be authorized to issue and serve subpoenas instantly upon such provider, his agent, servant or employee for the production of the books, papers, documents, medical charts, prescriptions or other records during an audit or investigation of the provider. If any provider or his agent, servant or employee should refuse to produce the records after being duly subpoenaed, the director shall be authorized to certify such facts and institute contempt proceedings in the manner, time, and place as authorized by law for administrative proceedings. As an additional remedy, the division shall be authorized to recover all amounts paid to the provider covering the period of the audit or investigation, inclusive of a legal rate of interest and a reasonable attorney's fee and costs of court if suit becomes necessary. Division staff shall have immediate access to the provider's physical location, facilities, records, documents, books, and any other records relating to medical care and services rendered to recipients during regular business hours.

(5) If any person in proceedings before the division disobeys or resists any lawful order or process, or misbehaves during a hearing or so near the place thereof as to obstruct the same, or neglects to produce, after having been ordered to do so, any pertinent book, paper or document, or refuses to appear after having been subpoenaed, or upon appearing refuses to take the oath as a witness, or after having taken the oath refuses to be examined according to law, the director shall certify the facts to any court having jurisdiction in the place in which it is sitting, and the court shall thereupon, in a summary manner, hear the evidence as to the acts complained of, and if the evidence so warrants, punish such person in the same manner and to the same extent as for a contempt committed before the court, or commit such person upon the same condition as if the doing of the forbidden act had occurred with reference to the process of, or in the presence of, the court.

(6) In suspending or terminating any provider from participation in the Medicaid program, the division shall preclude such provider from submitting claims for payment, either personally or through any clinic, group, corporation or other association to the division or its fiscal agents for any services or supplies provided under the Medicaid program except for those services or supplies provided prior to the suspension or termination. No clinic, group, corporation or other association which is a provider of services shall submit claims for payment to the division or its fiscal agents for any services or supplies provided by a person within such organization who has been suspended or terminated from participation in the Medicaid program except for those services or supplies provided prior to the suspension or termination. When this provision is violated by a provider of services which is a clinic, group, corporation or other association, the division may suspend or terminate such organization from participation. Suspension may be applied by the

division to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the provider is affiliated where such conduct was accomplished with the course of his official duty or was effectuated by him with the knowledge or approval of such person.

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

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

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

(c) Conviction under federal or state law of a criminal offense relating to the delivery of any goods, services or supplies, including the performance of management or administrative services relating to the delivery of the goods, services or supplies, under the Medicaid program, any other

state's Medicaid program, Medicare or any other public or private health or health insurance program.

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

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

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

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

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

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

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

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

(l) Failure to meet any condition of enrollment.

SECTION 3. Section 43-13-123, Mississippi Code of 1972, is amended as follows:

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

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

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

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

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

SECTION 4. Section 43-13-145, Mississippi Code of 1972, is amended as follows:

43-13-145. (1) Upon each nursing facility licensed or certified by the State of Mississippi and each intermediate care facility for the mentally retarded licensed by the State of Mississippi, there is levied an assessment in an amount set by the division not exceeding Two Dollars ($2.00) per day, or fraction thereof, for each * * * licensed or certified bed of the facility. The division may apply for a waiver from the U.S. Secretary of Health and Human Services to exempt nonprofit, public, charitable or religious facilities from the assessment levied under this

subsection, and if a waiver is granted, such facilities shall be exempt from any assessment levied under this subsection after the date that the division receives notice that the waiver has been granted.

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

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

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

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

SECTION 5. Section 41-7-191, Mississippi Code of 1972, is amended as follows:

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

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

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

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

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

(i) Open heart surgery services;

(ii) Cardiac catheterization services;

(iii) Comprehensive inpatient rehabilitation services;

(iv) Licensed psychiatric services;

(v) Licensed chemical dependency services;

(vi) Radiation therapy services;

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

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

(ix) Home health services;

(x) Swing-bed services;

(xi) Ambulatory surgical services;

(xii) Magnetic resonance imaging services;

(xiii) Extracorporeal shock wave lithotripsy services;

(xiv) Long-term care hospital services;

(xv) Positron Emission Tomography (PET) services;

(e) The relocation of one or more health services from one physical facility or site to another physical facility or site, unless such relocation, which does not involve a capital expenditure by or on behalf of a health care facility, (i) is to a physical facility or site within one thousand three hundred twenty (1,320) feet from the main entrance of the health care facility where the health care service is located, or (ii) is the result of an order of a court of appropriate jurisdiction or a result of pending litigation in such court, or by order of the State Department of Health, or by order of any other agency or legal entity of the state, the federal government, or any political subdivision of either, whose order is also approved by the State Department of Health;

(f) The acquisition or otherwise control of any major medical equipment for the provision of medical services; provided, however, (i) the acquisition of any major medical equipment used

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

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

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

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

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

(k) The contracting of a health care facility as defined in subparagraphs (i) through (viii) of Section 41-7-173(h) to establish a home office, subunit, or branch office in the space

operated as a health care facility through a formal arrangement with an existing health care facility as defined in subparagraph (ix) of Section 41-7-173(h).

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

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

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

(c) The department may issue a certificate of need for the addition to or expansion of any skilled nursing facility that is part of an existing continuing care retirement community located in Madison County, provided that the recipient of the certificate of need agrees in writing that the skilled nursing facility will not at any time participate in the Medicaid program

(Section 43-13-101 et seq.) or admit or keep any patients in the skilled nursing facility who are participating in the Medicaid program. This written agreement by the recipient of the certificate of need shall be fully binding on any subsequent owner of the skilled nursing facility, if the ownership of the facility is transferred at any time after the issuance of the certificate of need. Agreement that the skilled nursing facility will not participate in the Medicaid program shall be a condition of the issuance of a certificate of need to any person under this paragraph (c), and if such skilled nursing facility at any time after the issuance of the certificate of need, regardless of the ownership of the facility, participates in the Medicaid program or admits or keeps any patients in the facility who are participating in the Medicaid program, the State Department of Health shall revoke the certificate of need, if it is still outstanding, and shall deny or revoke the license of the skilled nursing facility, at the time that the department determines, after a hearing complying with due process, that the facility has failed to comply with any of the conditions upon which the certificate of need was issued, as provided in this paragraph and in the written agreement by the recipient of the certificate of need. The total number of beds that may be authorized under the authority of this paragraph (c) shall not exceed sixty (60) beds.

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

(e) The State Department of Health may issue a certificate of need for the construction of a nursing facility or

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

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

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

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

(i) The department may issue a certificate of need for the new construction of a skilled nursing facility in Leake

County, provided that the recipient of the certificate of need agrees in writing that the skilled nursing facility will not at any time participate in the Medicaid program (Section 43-13-101 et seq.) or admit or keep any patients in the skilled nursing facility who are participating in the Medicaid program. This written agreement by the recipient of the certificate of need shall be fully binding on any subsequent owner of the skilled nursing facility, if the ownership of the facility is transferred at any time after the issuance of the certificate of need. Agreement that the skilled nursing facility will not participate in the Medicaid program shall be a condition of the issuance of a certificate of need to any person under this paragraph (i), and if such skilled nursing facility at any time after the issuance of the certificate of need, regardless of the ownership of the facility, participates in the Medicaid program or admits or keeps any patients in the facility who are participating in the Medicaid program, the State Department of Health shall revoke the certificate of need, if it is still outstanding, and shall deny or revoke the license of the skilled nursing facility, at the time that the department determines, after a hearing complying with due process, that the facility has failed to comply with any of the conditions upon which the certificate of need was issued, as provided in this paragraph and in the written agreement by the recipient of the certificate of need. The provision of Section 43-7-193(1) regarding substantial compliance of the projection of need as reported in the current State Health Plan is waived for the purposes of this paragraph. The total number of nursing facility beds that may be authorized by any certificate of need issued under this paragraph (i) shall not exceed sixty (60) beds. If the skilled nursing facility authorized by the certificate of need issued under this paragraph is not constructed and fully operational within eighteen (18) months after July 1, 1994, the State Department of Health, after a hearing complying with due

process, shall revoke the certificate of need, if it is still outstanding, and shall not issue a license for the skilled nursing facility at any time after the expiration of the eighteen-month period.

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

(k) The department may issue a certificate of need for the construction of a nursing facility at a continuing care retirement community in Lowndes County. The total number of beds that may be authorized under the authority of this paragraph (k) shall not exceed sixty (60) beds. From and after July 1, 2001, the prohibition on the facility participating in the Medicaid program (Section 43-13-101 et seq.) that was a condition of issuance of the certificate of need under this paragraph (k) shall be revised as follows: The nursing facility may participate in the Medicaid program from and after July 1, 2001, if the owner of the facility on July 1, 2001, agrees in writing that no more than thirty (30) of the beds at the facility will be certified for participation in the Medicaid program, and that no claim will be submitted for Medicaid reimbursement for more than thirty (30) patients in the facility in any month or for any patient in the facility who is in a bed that is not Medicaid-certified. This written agreement by the owner of the facility shall be a condition of licensure of the facility, and the agreement shall be

fully binding on any subsequent owner of the facility if the ownership of the facility is transferred at any time after July 1, 2001. After this written agreement is executed, the Division of Medicaid and the State Department of Health shall not certify more than thirty (30) of the beds in the facility for participation in the Medicaid program. If the facility violates the terms of the written agreement by admitting or keeping in the facility on a regular or continuing basis more than thirty (30) patients who are participating in the Medicaid program, the State Department of Health shall revoke the license of the facility, at the time that the department determines, after a hearing complying with due process, that the facility has violated the written agreement.

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

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

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

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

certificate of need is issued and substantial construction of the nursing facility beds has not commenced within eighteen (18) months after the effective date of July 1, 1998, the State Department of Health, after a hearing complying with due process, shall revoke the certificate of need if it is still outstanding, and the department shall not issue a license for the nursing facility at any time after the eighteen-month period. Provided, however, that if the issuance of the certificate of need is contested, the department shall require substantial construction of the nursing facility beds within six (6) months after final adjudication on the issuance of the certificate of need.

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

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

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

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

after final adjudication on the issuance of the certificate of need.

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

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

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

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

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

an application is received for nursing facility beds in an eligible county from the state at large.

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

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

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

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

qualifications of the other applicants for the certificate of need.

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

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

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

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

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

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

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

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

(c) Of the total number of beds authorized under this subsection, the department shall issue a certificate of need to a hospital currently operating Medicaid-certified acute psychiatric beds for adolescents in DeSoto County, for the establishment of a forty-bed psychiatric residential treatment facility in DeSoto County, provided that the hospital agrees in writing (i) that the hospital shall give priority for the use of those forty (40) beds to Mississippi residents who are presently being treated in out-of-state facilities, and (ii) that no more than fifteen (15) of the beds at the psychiatric residential treatment facility will be certified for participation in the Medicaid program (Section 43-13-101 et seq.), and that no claim will be submitted for Medicaid reimbursement for more than fifteen (15) patients in the psychiatric residential treatment facility in any day or for any patient in the psychiatric residential treatment facility who is in a bed that is not Medicaid-certified. This written agreement by the recipient of the certificate of need shall be a condition of the issuance of the certificate of need under this paragraph, and the agreement shall be fully binding on any subsequent owner of the psychiatric residential treatment facility if the ownership of the facility is transferred at any time after the issuance of the certificate of need. After this written agreement is executed, the Division of Medicaid and the State Department of Health shall not certify more than fifteen (15) of the beds in the psychiatric residential treatment facility for participation in the Medicaid program. If the psychiatric residential treatment facility violates the terms of the written agreement by admitting or keeping in the facility on a regular or continuing basis more than fifteen (15) patients who are participating in the Medicaid program, the State Department of Health shall revoke the license of the facility, at the time that the department determines, after a hearing complying with due process, that the facility has violated the condition upon which the certificate of need was

issued, as provided in this paragraph and in the written agreement.

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

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

(f) The department shall issue a certificate of need to a one-hundred-thirty-four-bed specialty hospital located on twenty-nine and forty-four one-hundredths (29.44) commercial acres at 5900 Highway 39 North in Meridian (Lauderdale County), Mississippi, for the addition, construction or expansion of child/adolescent psychiatric residential treatment facility beds in Lauderdale County. As a condition of issuance of the certificate of need under this paragraph, the facility shall give priority in admissions to the child/adolescent psychiatric residential treatment facility beds authorized under this paragraph to patients who otherwise would require out-of-state placement. *** * *** For purposes of this paragraph, the provisions of Section 41-7-193(1) requiring substantial compliance with the projection of need as reported in the current State Health Plan are waived. The total number of child/adolescent psychiatric

residential treatment facility beds that may be authorized under the authority of this paragraph shall be sixty (60) beds. There shall be no prohibition or restrictions on participation in the Medicaid program (Section 43-13-101 et seq.) for the person receiving the certificate of need authorized under this paragraph or for the beds converted pursuant to the authority of that certificate of need.

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

(i) The department may issue certificates of need to any person for any purpose described in this subsection, provided that the hospital, psychiatric hospital or chemical dependency hospital does not participate in the Medicaid program (Section 43-13-101 et seq.) at the time of the application for the certificate of need and the owner of the hospital, psychiatric hospital or chemical dependency hospital agrees in writing that the hospital, psychiatric hospital or chemical dependency hospital will not at any time participate in the Medicaid program or admit or keep any patients who are participating in the Medicaid program

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

(ii) The department may issue a certificate of need for the conversion of existing beds in a county hospital in Choctaw County from acute care beds to child/adolescent chemical dependency beds. For purposes of this subparagraph, the provisions of Section 41-7-193(1) requiring substantial compliance with the projection of need as reported in the current State Health Plan is waived. The total number of beds that may be authorized under authority of this subparagraph shall not exceed

twenty (20) beds. There shall be no prohibition or restrictions on participation in the Medicaid program (Section 43-13-101 et seq.) for the hospital receiving the certificate of need authorized under this subparagraph (a)(ii) or for the beds converted pursuant to the authority of that certificate of need.

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

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

(iv) The department shall issue a certificate of need to the Region 7 Mental Health/Retardation Commission for the construction or expansion of child/adolescent psychiatric beds or

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

(v) The department may issue a certificate of need to any county hospital located in Leflore County for the construction or expansion of adult psychiatric beds or the conversion of other beds to adult psychiatric beds, not to exceed twenty (20) beds, provided that the recipient of the certificate of need agrees in writing that the adult psychiatric beds will not at any time be certified for participation in the Medicaid program and that the hospital will not admit or keep any patients who are participating in the Medicaid program in any of such adult psychiatric beds. This written agreement by the recipient of the certificate of need shall be fully binding on any subsequent owner of the hospital if the ownership of the hospital is transferred at any time after the issuance of the certificate of need. Agreement that the adult psychiatric beds will not be certified for participation in the Medicaid program shall be a condition of the issuance of a certificate of need to any person under this subparagraph (a)(v), and if such hospital at any time after the issuance of the certificate of need, regardless of the ownership of the hospital, has any of such adult psychiatric beds certified for participation in the Medicaid program or admits or keeps any Medicaid patients in such adult psychiatric beds, the State Department of Health shall revoke the certificate of need, if it

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

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

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

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

(6) The State Department of Health shall issue a certificate of need to a Mississippi corporation qualified to manage a long-term care hospital as defined in Section 41-7-173(h)(xii) in

Harrison County, not to exceed eighty (80) beds, including any necessary renovation or construction required for licensure and certification, provided that the recipient of the certificate of need agrees in writing that the long-term care hospital will not at any time participate in the Medicaid program (Section 43-13-101 et seq.) or admit or keep any patients in the long-term care hospital who are participating in the Medicaid program. This written agreement by the recipient of the certificate of need shall be fully binding on any subsequent owner of the long-term care hospital, if the ownership of the facility is transferred at any time after the issuance of the certificate of need. Agreement that the long-term care hospital will not participate in the Medicaid program shall be a condition of the issuance of a certificate of need to any person under this subsection (6), and if such long-term care hospital at any time after the issuance of the certificate of need, regardless of the ownership of the facility, participates in the Medicaid program or admits or keeps any patients in the facility who are participating in the Medicaid program, the State Department of Health shall revoke the certificate of need, if it is still outstanding, and shall deny or revoke the license of the long-term care hospital, at the time that the department determines, after a hearing complying with due process, that the facility has failed to comply with any of the conditions upon which the certificate of need was issued, as provided in this subsection and in the written agreement by the recipient of the certificate of need. For purposes of this subsection, the provision of Section 41-7-193(1) requiring substantial compliance with the projection of need as reported in the current State Health Plan is hereby waived.

(7) The State Department of Health may issue a certificate of need to any hospital in the state to utilize a portion of its beds for the "swing-bed" concept. Any such hospital must be in conformance with the federal regulations regarding such swing-bed

concept at the time it submits its application for a certificate of need to the State Department of Health, except that such hospital may have more licensed beds or a higher average daily census (ADC) than the maximum number specified in federal regulations for participation in the swing-bed program. Any hospital meeting all federal requirements for participation in the swing-bed program which receives such certificate of need shall render services provided under the swing-bed concept to any patient eligible for Medicare (Title XVIII of the Social Security Act) who is certified by a physician to be in need of such services, and no such hospital shall permit any patient who is eligible for both Medicaid and Medicare or eligible only for Medicaid to stay in the swing beds of the hospital for more than thirty (30) days per admission unless the hospital receives prior approval for such patient from the Division of Medicaid, Office of the Governor. Any hospital having more licensed beds or a higher average daily census (ADC) than the maximum number specified in federal regulations for participation in the swing-bed program which receives such certificate of need shall develop a procedure to insure that before a patient is allowed to stay in the swing beds of the hospital, there are no vacant nursing home beds available for that patient located within a fifty-mile radius of the hospital. When any such hospital has a patient staying in the swing beds of the hospital and the hospital receives notice from a nursing home located within such radius that there is a vacant bed available for that patient, the hospital shall transfer the patient to the nursing home within a reasonable time after receipt of the notice. Any hospital which is subject to the requirements of the two (2) preceding sentences of this subsection may be suspended from participation in the swing-bed program for a reasonable period of time by the State Department of Health if the department, after a hearing complying with due process, determines

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

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

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

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

(11) The new construction, renovation or expansion of or addition to any health care facility defined in subparagraph (ii) (psychiatric hospital), subparagraph (iv) (skilled nursing facility), subparagraph (vi) (intermediate care facility), subparagraph (viii) (intermediate care facility for the mentally retarded) and subparagraph (x) (psychiatric residential treatment facility) of Section 41-7-173(h) which is owned by the State of Mississippi and under the direction and control of the State Department of Mental Health, and the addition of new beds or the

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

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

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

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

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

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

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

nursing facility component must contain a minimum of thirty (30) beds. Any nursing facility beds authorized by this section will not be counted against the bed need set forth in the State Health Plan, as identified in Section 41-7-171, et seq.

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

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

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

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

SECTION 6. This act shall take effect and be in force from and after its passage.