

By: Senator(s) Huggins

To: Public Health and
Welfare; Appropriations

SENATE BILL NO. 2189

1 AN ACT RELATING TO THE MISSISSIPPI MEDICAID LAW; TO AMEND
2 SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO AUTHORIZE
3 UNLIMITED DAY REIMBURSEMENT FOR DISPROPORTIONATE SHARE PROGRAM
4 HOSPITALS FOR ELIGIBLE CHILDREN UNDER THE AGE OF SIX ONLY IF
5 CERTIFIED AS MEDICALLY NECESSARY, TO AUTHORIZE THE DIVISION OF
6 MEDICAID TO ESTABLISH A MEDICARE UPPER PAYMENT LIMITS PROGRAM FOR
7 OUTPATIENT HOSPITAL SERVICES, TO AUTHORIZE THE DIVISION OF
8 MEDICAID TO ESTABLISH A MEDICARE UPPER PAYMENT LIMITS PROGRAM FOR
9 NURSING FACILITY SERVICES, TO REQUIRE THAT NURSING FACILITIES THAT
10 PARTICIPATE IN THE MEDICAID PROGRAM ALSO BE CERTIFIED TO
11 PARTICIPATE IN THE MEDICARE PROGRAM, TO DELETE SPECIFIC FEE
12 INCREASES FOR PERIODIC SCREENING AND DIAGNOSTIC SERVICES, TO
13 REVISE THE CONDITIONS FOR REIMBURSEMENT OF THE COST OF EYEGLASSES
14 FOR RECIPIENTS, TO CLARIFY THE REQUIREMENT FOR DISPROPORTIONATE
15 SHARE PROGRAM HOSPITALS TO PARTICIPATE IN THE FEDERAL
16 INTERGOVERNMENTAL TRANSFER PROGRAM, TO CHANGE CERTAIN REFERENCES
17 TO THE FEDERAL INDIVIDUALS WITH DISABILITIES EDUCATION ACT, TO
18 AUTHORIZE MEDICAID REIMBURSEMENT TO RURAL HEALTH CENTERS FOR
19 AMBULATORY SERVICES, TO AUTHORIZE MEDICAID REIMBURSEMENT TO
20 CHIROPRACTORS FOR X-RAYS PERFORMED TO DOCUMENT CONDITIONS, AND TO
21 AUTHORIZE THE DIVISION TO DEVELOP AND IMPLEMENT A DISEASE
22 MANAGEMENT PROGRAM; TO AMEND SECTION 43-13-121, MISSISSIPPI CODE
23 OF 1972, TO CLARIFY AND REVISE THE CONDITIONS FOR DENYING OR
24 REVOKING PROVIDER ENROLLMENT IN THE MEDICAID PROGRAM; TO AMEND
25 SECTION 43-13-123, MISSISSIPPI CODE OF 1972, TO CLARIFY THAT THE
26 DIVISION SHALL OBTAIN SERVICES PURSUANT TO REGULATIONS OF THE
27 PERSONAL SERVICE CONTRACT REVIEW BOARD; TO AMEND SECTION
28 43-13-145, MISSISSIPPI CODE OF 1972, TO CLARIFY THAT THE MEDICAID
29 ASSESSMENT IS TO BE ON ALL LICENSED OR CERTIFIED NURSING FACILITY
30 BEDS IN THE STATE; TO AMEND SECTION 41-7-191, MISSISSIPPI CODE OF
31 1972, TO DELETE THE REQUIREMENT THAT THE DIVISION OF MEDICAID
32 FURNISH A CERTAIN RESIDENTIAL FACILITY THE NAMES AND MEDICAL
33 INFORMATION ABOUT RECIPIENTS RECEIVING SERVICES OUT OF STATE; AND
34 FOR RELATED PURPOSES.

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

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

38 43-13-117. Medical assistance as authorized by this article
39 shall include payment of part or all of the costs, at the
40 discretion of the division or its successor, with approval of the
41 Governor, of the following types of care and services rendered to
42 eligible applicants who shall have been determined to be eligible



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

45 (1) Inpatient hospital services.

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

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

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

67 (2) Outpatient hospital services.

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



76 1999. The committee shall make a recommendation on the specific
77 cost-to-charge reimbursement method for outpatient hospital
78 services to the 2000 Regular Session of the Legislature.

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

90 (3) Laboratory and x-ray services.

91 (4) Nursing facility services.

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

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



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

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

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

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



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

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



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

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

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

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

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

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

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

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



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

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

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



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

244 * * *

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

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

263 (b) Repealed.

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



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

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

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

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

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

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



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

310 (10) Dental care that is an adjunct to treatment of an
311 acute medical or surgical condition; services of oral surgeons and
312 dentists in connection with surgery related to the jaw or any
313 structure contiguous to the jaw or the reduction of any fracture
314 of the jaw or any facial bone; and emergency dental extractions
315 and treatment related thereto. On July 1, 1999, all fees for
316 dental care and surgery under authority of this paragraph (10)
317 shall be increased to one hundred sixty percent (160%) of the
318 amount of the reimbursement rate that was in effect on June 30,
319 1999. It is the intent of the Legislature to encourage more
320 dentists to participate in the Medicaid program.

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

331 (12) Intermediate care facility services.

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



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

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

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

346 (14) Clinic services. Such diagnostic, preventive,
347 therapeutic, rehabilitative or palliative services furnished to an
348 outpatient by or under the supervision of a physician or dentist
349 in a facility which is not a part of a hospital but which is
350 organized and operated to provide medical care to outpatients.
351 Clinic services shall include any services reimbursed as
352 outpatient hospital services which may be rendered in such a
353 facility, including those that become so after July 1, 1991. On
354 July 1, 1999, all fees for physicians' services reimbursed under
355 authority of this paragraph (14) shall be reimbursed at ninety
356 percent (90%) of the rate established on January 1, 1999, and as
357 adjusted each January thereafter, under Medicare (Title XVIII of
358 the Social Security Act, as amended), and which shall in no event
359 be less than seventy percent (70%) of the rate established on
360 January 1, 1994. All fees for physicians' services that are
361 covered by both Medicare and Medicaid shall be reimbursed at ten
362 percent (10%) of the adjusted Medicare payment established on
363 January 1, 1999, and as adjusted each January thereafter, under
364 Medicare (Title XVIII of the Social Security Act, as amended), and
365 which shall in no event be less than seventy percent (70%) of the
366 adjusted Medicare payment established on January 1, 1994. On July
367 1, 1999, all fees for dentists' services reimbursed under
368 authority of this paragraph (14) shall be increased to one hundred
369 sixty percent (160%) of the amount of the reimbursement rate that
370 was in effect on June 30, 1999.



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

387 (16) Mental health services. Approved therapeutic and
388 case management services provided by (a) an approved regional
389 mental health/retardation center established under Sections
390 41-19-31 through 41-19-39, or by another community mental health
391 service provider meeting the requirements of the Department of
392 Mental Health to be an approved mental health/retardation center
393 if determined necessary by the Department of Mental Health, using
394 state funds which are provided from the appropriation to the State
395 Department of Mental Health and used to match federal funds under
396 a cooperative agreement between the division and the department,
397 or (b) a facility which is certified by the State Department of
398 Mental Health to provide therapeutic and case management services,
399 to be reimbursed on a fee for service basis. Any such services
400 provided by a facility described in paragraph (b) must have the
401 prior approval of the division to be reimbursable under this
402 section. After June 30, 1997, mental health services provided by
403 regional mental health/retardation centers established under



404 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
405 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
406 psychiatric residential treatment facilities as defined in Section
407 43-11-1, or by another community mental health service provider
408 meeting the requirements of the Department of Mental Health to be
409 an approved mental health/retardation center if determined
410 necessary by the Department of Mental Health, shall not be
411 included in or provided under any capitated managed care pilot
412 program provided for under paragraph (24) of this section.

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

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

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



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

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

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

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



470 then shall be used to provide expanded targeted case management
471 services for Medicaid eligible children with special needs who are
472 eligible for the state's early intervention system.

473 Qualifications for persons providing service coordination shall be
474 determined by the State Department of Health and the Division of
475 Medicaid.

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

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

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

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



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

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

528 (25) Birthing center services.

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



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

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

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

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

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

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

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



569 (33) Podiatrist services.

570 (34) The division shall make application to the United
571 States Health Care Financing Administration for a waiver to
572 develop a program of services to personal care and assisted living
573 homes in Mississippi. This waiver shall be completed by December
574 1, 1999.

575 (35) Services and activities authorized in Sections
576 43-27-101 and 43-27-103, using state funds that are provided from
577 the appropriation to the State Department of Human Services and
578 used to match federal funds under a cooperative agreement between
579 the division and the department.

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

587 (37) [Deleted]

588 (38) Chiropractic services: a chiropractor's manual
589 manipulation of the spine to correct a subluxation, if x-ray
590 demonstrates that a subluxation exists and if the subluxation has
591 resulted in a neuromusculoskeletal condition for which
592 manipulation is appropriate treatment, and related spinal x-rays
593 performed to document these conditions. Reimbursement for
594 chiropractic services shall not exceed Seven Hundred Dollars
595 (\$700.00) per year per beneficiary.

596 (39) Dually eligible Medicare/Medicaid beneficiaries.
597 The division shall pay the Medicare deductible and ten percent
598 (10%) coinsurance amounts for services available under Medicare
599 for the duration and scope of services otherwise available under
600 the Medicaid program.

601 (40) [Deleted]



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

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

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

625 (44) Nursing facility services for the severely
626 disabled.

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

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



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

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

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

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



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

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

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



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

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

707 43-13-121. (1) The division is authorized and empowered to
708 administer a program of medical assistance under the provisions of
709 this article, and to do the following:

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

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

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

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

725 (iv) Providing for fair and impartial hearings;

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

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

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



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

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

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

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

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

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



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

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

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

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

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

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

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



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

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

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

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



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

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

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

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

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



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



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

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



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

939 (7) The division may deny or revoke enrollment in the
940 Medicaid program to a provider if any of the following are found
941 to be applicable to the provider, his agent, a managing employee,
942 or any person having an ownership interest equal to five percent
943 (5%) or greater in the provider:

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

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

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



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

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

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

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

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

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

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

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

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

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

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



997 43-13-123. The determination of the method of providing
998 payment of claims under this article shall be made by the
999 division, with approval of the Governor, which methods may be:

1000 (1) By contract with insurance companies licensed to do
1001 business in the State of Mississippi or with nonprofit hospital
1002 service corporations, medical or dental service corporations,
1003 authorized to do business in Mississippi to underwrite on an
1004 insured premium approach, such medical assistance benefits as may
1005 be available, and any carrier selected pursuant to the provisions
1006 of this article is hereby expressly authorized and empowered to
1007 undertake the performance of the requirements of such contract.

1008 (2) By contract with an insurance company licensed to
1009 do business in the State of Mississippi or with nonprofit hospital
1010 service, medical or dental service organizations, or other
1011 organizations including data processing companies, authorized to
1012 do business in Mississippi to act as fiscal agent.

1013 The division shall obtain services to be provided under
1014 either of the above-described provisions pursuant to the Personal
1015 Service Contract Review Board Procurement Regulations. * * *

1016 The authorization of the foregoing methods shall not preclude
1017 other methods of providing payment of claims through direct
1018 operation of the program by the state or its agencies.

1019 **SECTION 4.** Section 43-13-145, Mississippi Code of 1972, is
1020 amended as follows:

1021 43-13-145. (1) Upon each nursing facility licensed or
1022 certified by the State of Mississippi and each intermediate care
1023 facility for the mentally retarded licensed by the State of
1024 Mississippi, there is levied an assessment in an amount set by the
1025 division not exceeding Two Dollars (\$2.00) per day, or fraction
1026 thereof, for each * * * licensed or certified bed of the facility.
1027 The division may apply for a waiver from the U.S. Secretary of
1028 Health and Human Services to exempt nonprofit, public, charitable
1029 or religious facilities from the assessment levied under this



1030 subsection, and if a waiver is granted, such facilities shall be
1031 exempt from any assessment levied under this subsection after the
1032 date that the division receives notice that the waiver has been
1033 granted.

1034 (2) The assessment levied under this section shall be
1035 collected by the division each quarter beginning on July 1, 1992,
1036 and shall be based on data for the quarter ending three (3) months
1037 before the date the assessments are to be collected.

1038 (3) All assessments collected under this section shall be
1039 deposited in the Medical Care Fund created by Section 43-13-143.

1040 (4) The assessment levied under this section shall be in
1041 addition to any other assessments, taxes or fees levied by law.

1042 (5) The assessment levied under this section shall
1043 constitute a debt due the State of Mississippi from the time the
1044 assessment is due until it is paid. If any facility liable for
1045 payment of such assessment does not pay the assessment when it is
1046 due, the division shall give written notice to the facility
1047 demanding payment of the assessment within ten (10) days from the
1048 date of delivery of the notice. Such notice shall be sent by
1049 certified or registered mail or delivered to the facility by an
1050 agent of the division. If any facility liable for the assessment
1051 fails or refuses to pay it after receiving the notice and demand,
1052 the division may withhold the Medicaid reimbursement payments that
1053 are otherwise scheduled to be made to the facility from the time
1054 the assessment is due until it is paid by the facility.

1055 **SECTION 5.** Section 41-7-191, Mississippi Code of 1972, is
1056 amended as follows:

1057 41-7-191. (1) No person shall engage in any of the
1058 following activities without obtaining the required certificate of
1059 need:

1060 (a) The construction, development or other
1061 establishment of a new health care facility;



1062 (b) The relocation of a health care facility or portion
1063 thereof, or major medical equipment, unless such relocation of a
1064 health care facility or portion thereof, or major medical
1065 equipment, which does not involve a capital expenditure by or on
1066 behalf of a health care facility, is within five thousand two
1067 hundred eighty (5,280) feet from the main entrance of the health
1068 care facility;

1069 (c) A change over a period of two (2) years' time, as
1070 established by the State Department of Health, in existing bed
1071 complement through the addition of more than ten (10) beds or more
1072 than ten percent (10%) of the total bed capacity of a designated
1073 licensed category or subcategory of any health care facility,
1074 whichever is less, from one physical facility or site to another;
1075 the conversion over a period of two (2) years' time, as
1076 established by the State Department of Health, of existing bed
1077 complement of more than ten (10) beds or more than ten percent
1078 (10%) of the total bed capacity of a designated licensed category
1079 or subcategory of any such health care facility, whichever is
1080 less; or the alteration, modernizing or refurbishing of any unit
1081 or department wherein such beds may be located; provided, however,
1082 that from and after July 1, 1994, no health care facility shall be
1083 authorized to add any beds or convert any beds to another category
1084 of beds without a certificate of need under the authority of
1085 subsection (1)(c) of this section unless there is a projected need
1086 for such beds in the planning district in which the facility is
1087 located, as reported in the most current State Health Plan;

1088 (d) Offering of the following health services if those
1089 services have not been provided on a regular basis by the proposed
1090 provider of such services within the period of twelve (12) months
1091 prior to the time such services would be offered:

1092 (i) Open heart surgery services;

1093 (ii) Cardiac catheterization services;



1094 (iii) Comprehensive inpatient rehabilitation
1095 services;

1096 (iv) Licensed psychiatric services;

1097 (v) Licensed chemical dependency services;

1098 (vi) Radiation therapy services;

1099 (vii) Diagnostic imaging services of an invasive
1100 nature, i.e. invasive digital angiography;

1101 (viii) Nursing home care as defined in
1102 subparagraphs (iv), (vi) and (viii) of Section 41-7-173(h);

1103 (ix) Home health services;

1104 (x) Swing-bed services;

1105 (xi) Ambulatory surgical services;

1106 (xii) Magnetic resonance imaging services;

1107 (xiii) Extracorporeal shock wave lithotripsy
1108 services;

1109 (xiv) Long-term care hospital services;

1110 (xv) Positron Emission Tomography (PET) services;

1111 (e) The relocation of one or more health services from
1112 one physical facility or site to another physical facility or
1113 site, unless such relocation, which does not involve a capital
1114 expenditure by or on behalf of a health care facility, (i) is to a
1115 physical facility or site within one thousand three hundred twenty
1116 (1,320) feet from the main entrance of the health care facility
1117 where the health care service is located, or (ii) is the result of
1118 an order of a court of appropriate jurisdiction or a result of
1119 pending litigation in such court, or by order of the State
1120 Department of Health, or by order of any other agency or legal
1121 entity of the state, the federal government, or any political
1122 subdivision of either, whose order is also approved by the State
1123 Department of Health;

1124 (f) The acquisition or otherwise control of any major
1125 medical equipment for the provision of medical services; provided,
1126 however, (i) the acquisition of any major medical equipment used



1127 only for research purposes, and (ii) the acquisition of major
1128 medical equipment to replace medical equipment for which a
1129 facility is already providing medical services and for which the
1130 State Department of Health has been notified before the date of
1131 such acquisition shall be exempt from this paragraph; an
1132 acquisition for less than fair market value must be reviewed, if
1133 the acquisition at fair market value would be subject to review;

1134 (g) Changes of ownership of existing health care
1135 facilities in which a notice of intent is not filed with the State
1136 Department of Health at least thirty (30) days prior to the date
1137 such change of ownership occurs, or a change in services or bed
1138 capacity as prescribed in paragraph (c) or (d) of this subsection
1139 as a result of the change of ownership; an acquisition for less
1140 than fair market value must be reviewed, if the acquisition at
1141 fair market value would be subject to review;

1142 (h) The change of ownership of any health care facility
1143 defined in subparagraphs (iv), (vi) and (viii) of Section
1144 41-7-173(h), in which a notice of intent as described in paragraph
1145 (g) has not been filed and if the Executive Director, Division of
1146 Medicaid, Office of the Governor, has not certified in writing
1147 that there will be no increase in allowable costs to Medicaid from
1148 revaluation of the assets or from increased interest and
1149 depreciation as a result of the proposed change of ownership;

1150 (i) Any activity described in paragraphs (a) through
1151 (h) if undertaken by any person if that same activity would
1152 require certificate of need approval if undertaken by a health
1153 care facility;

1154 (j) Any capital expenditure or deferred capital
1155 expenditure by or on behalf of a health care facility not covered
1156 by paragraphs (a) through (h);

1157 (k) The contracting of a health care facility as
1158 defined in subparagraphs (i) through (viii) of Section 41-7-173(h)
1159 to establish a home office, subunit, or branch office in the space



1160 operated as a health care facility through a formal arrangement
1161 with an existing health care facility as defined in subparagraph
1162 (ix) of Section 41-7-173(h).

1163 (2) The State Department of Health shall not grant approval
1164 for or issue a certificate of need to any person proposing the new
1165 construction of, addition to, or expansion of any health care
1166 facility defined in subparagraphs (iv) (skilled nursing facility)
1167 and (vi) (intermediate care facility) of Section 41-7-173(h) or
1168 the conversion of vacant hospital beds to provide skilled or
1169 intermediate nursing home care, except as hereinafter authorized:

1170 (a) The department may issue a certificate of need to
1171 any person proposing the new construction of any health care
1172 facility defined in subparagraphs (iv) and (vi) of Section
1173 41-7-173(h) as part of a life care retirement facility, in any
1174 county bordering on the Gulf of Mexico in which is located a
1175 National Aeronautics and Space Administration facility, not to
1176 exceed forty (40) beds. From and after July 1, 1999, there shall
1177 be no prohibition or restrictions on participation in the Medicaid
1178 program (Section 43-13-101 et seq.) for the beds in the health
1179 care facility that were authorized under this paragraph (a).

1180 (b) The department may issue certificates of need in
1181 Harrison County to provide skilled nursing home care for
1182 Alzheimer's Disease patients and other patients, not to exceed one
1183 hundred fifty (150) beds. From and after July 1, 1999, there
1184 shall be no prohibition or restrictions on participation in the
1185 Medicaid program (Section 43-13-101 et seq.) for the beds in the
1186 nursing facilities that were authorized under this paragraph (b).

1187 (c) The department may issue a certificate of need for
1188 the addition to or expansion of any skilled nursing facility that
1189 is part of an existing continuing care retirement community
1190 located in Madison County, provided that the recipient of the
1191 certificate of need agrees in writing that the skilled nursing
1192 facility will not at any time participate in the Medicaid program



1193 (Section 43-13-101 et seq.) or admit or keep any patients in the
1194 skilled nursing facility who are participating in the Medicaid
1195 program. This written agreement by the recipient of the
1196 certificate of need shall be fully binding on any subsequent owner
1197 of the skilled nursing facility, if the ownership of the facility
1198 is transferred at any time after the issuance of the certificate
1199 of need. Agreement that the skilled nursing facility will not
1200 participate in the Medicaid program shall be a condition of the
1201 issuance of a certificate of need to any person under this
1202 paragraph (c), and if such skilled nursing facility at any time
1203 after the issuance of the certificate of need, regardless of the
1204 ownership of the facility, participates in the Medicaid program or
1205 admits or keeps any patients in the facility who are participating
1206 in the Medicaid program, the State Department of Health shall
1207 revoke the certificate of need, if it is still outstanding, and
1208 shall deny or revoke the license of the skilled nursing facility,
1209 at the time that the department determines, after a hearing
1210 complying with due process, that the facility has failed to comply
1211 with any of the conditions upon which the certificate of need was
1212 issued, as provided in this paragraph and in the written agreement
1213 by the recipient of the certificate of need. The total number of
1214 beds that may be authorized under the authority of this paragraph
1215 (c) shall not exceed sixty (60) beds.

1216 (d) The State Department of Health may issue a
1217 certificate of need to any hospital located in DeSoto County for
1218 the new construction of a skilled nursing facility, not to exceed
1219 one hundred twenty (120) beds, in DeSoto County. From and after
1220 July 1, 1999, there shall be no prohibition or restrictions on
1221 participation in the Medicaid program (Section 43-13-101 et seq.)
1222 for the beds in the nursing facility that were authorized under
1223 this paragraph (d).

1224 (e) The State Department of Health may issue a
1225 certificate of need for the construction of a nursing facility or



1226 the conversion of beds to nursing facility beds at a personal care
1227 facility for the elderly in Lowndes County that is owned and
1228 operated by a Mississippi nonprofit corporation, not to exceed
1229 sixty (60) beds. From and after July 1, 1999, there shall be no
1230 prohibition or restrictions on participation in the Medicaid
1231 program (Section 43-13-101 et seq.) for the beds in the nursing
1232 facility that were authorized under this paragraph (e).

1233 (f) The State Department of Health may issue a
1234 certificate of need for conversion of a county hospital facility
1235 in Itawamba County to a nursing facility, not to exceed sixty (60)
1236 beds, including any necessary construction, renovation or
1237 expansion. From and after July 1, 1999, there shall be no
1238 prohibition or restrictions on participation in the Medicaid
1239 program (Section 43-13-101 et seq.) for the beds in the nursing
1240 facility that were authorized under this paragraph (f).

1241 (g) The State Department of Health may issue a
1242 certificate of need for the construction or expansion of nursing
1243 facility beds or the conversion of other beds to nursing facility
1244 beds in either Hinds, Madison or Rankin Counties, not to exceed
1245 sixty (60) beds. From and after July 1, 1999, there shall be no
1246 prohibition or restrictions on participation in the Medicaid
1247 program (Section 43-13-101 et seq.) for the beds in the nursing
1248 facility that were authorized under this paragraph (g).

1249 (h) The State Department of Health may issue a
1250 certificate of need for the construction or expansion of nursing
1251 facility beds or the conversion of other beds to nursing facility
1252 beds in either Hancock, Harrison or Jackson Counties, not to
1253 exceed sixty (60) beds. From and after July 1, 1999, there shall
1254 be no prohibition or restrictions on participation in the Medicaid
1255 program (Section 43-13-101 et seq.) for the beds in the facility
1256 that were authorized under this paragraph (h).

1257 (i) The department may issue a certificate of need for
1258 the new construction of a skilled nursing facility in Leake



1259 County, provided that the recipient of the certificate of need
1260 agrees in writing that the skilled nursing facility will not at
1261 any time participate in the Medicaid program (Section 43-13-101 et
1262 seq.) or admit or keep any patients in the skilled nursing
1263 facility who are participating in the Medicaid program. This
1264 written agreement by the recipient of the certificate of need
1265 shall be fully binding on any subsequent owner of the skilled
1266 nursing facility, if the ownership of the facility is transferred
1267 at any time after the issuance of the certificate of need.
1268 Agreement that the skilled nursing facility will not participate
1269 in the Medicaid program shall be a condition of the issuance of a
1270 certificate of need to any person under this paragraph (i), and if
1271 such skilled nursing facility at any time after the issuance of
1272 the certificate of need, regardless of the ownership of the
1273 facility, participates in the Medicaid program or admits or keeps
1274 any patients in the facility who are participating in the Medicaid
1275 program, the State Department of Health shall revoke the
1276 certificate of need, if it is still outstanding, and shall deny or
1277 revoke the license of the skilled nursing facility, at the time
1278 that the department determines, after a hearing complying with due
1279 process, that the facility has failed to comply with any of the
1280 conditions upon which the certificate of need was issued, as
1281 provided in this paragraph and in the written agreement by the
1282 recipient of the certificate of need. The provision of Section
1283 43-7-193(1) regarding substantial compliance of the projection of
1284 need as reported in the current State Health Plan is waived for
1285 the purposes of this paragraph. The total number of nursing
1286 facility beds that may be authorized by any certificate of need
1287 issued under this paragraph (i) shall not exceed sixty (60) beds.
1288 If the skilled nursing facility authorized by the certificate of
1289 need issued under this paragraph is not constructed and fully
1290 operational within eighteen (18) months after July 1, 1994, the
1291 State Department of Health, after a hearing complying with due



1292 process, shall revoke the certificate of need, if it is still
1293 outstanding, and shall not issue a license for the skilled nursing
1294 facility at any time after the expiration of the eighteen-month
1295 period.

1296 (j) The department may issue certificates of need to
1297 allow any existing freestanding long-term care facility in
1298 Tishomingo County and Hancock County that on July 1, 1995, is
1299 licensed with fewer than sixty (60) beds. For the purposes of
1300 this paragraph (j), the provision of Section 41-7-193(1) requiring
1301 substantial compliance with the projection of need as reported in
1302 the current State Health Plan is waived. From and after July 1,
1303 1999, there shall be no prohibition or restrictions on
1304 participation in the Medicaid program (Section 43-13-101 et seq.)
1305 for the beds in the long-term care facilities that were authorized
1306 under this paragraph (j).

1307 (k) The department may issue a certificate of need for
1308 the construction of a nursing facility at a continuing care
1309 retirement community in Lowndes County. The total number of beds
1310 that may be authorized under the authority of this paragraph (k)
1311 shall not exceed sixty (60) beds. From and after July 1, 2001,
1312 the prohibition on the facility participating in the Medicaid
1313 program (Section 43-13-101 et seq.) that was a condition of
1314 issuance of the certificate of need under this paragraph (k) shall
1315 be revised as follows: The nursing facility may participate in
1316 the Medicaid program from and after July 1, 2001, if the owner of
1317 the facility on July 1, 2001, agrees in writing that no more than
1318 thirty (30) of the beds at the facility will be certified for
1319 participation in the Medicaid program, and that no claim will be
1320 submitted for Medicaid reimbursement for more than thirty (30)
1321 patients in the facility in any month or for any patient in the
1322 facility who is in a bed that is not Medicaid-certified. This
1323 written agreement by the owner of the facility shall be a
1324 condition of licensure of the facility, and the agreement shall be



1325 fully binding on any subsequent owner of the facility if the
1326 ownership of the facility is transferred at any time after July 1,
1327 2001. After this written agreement is executed, the Division of
1328 Medicaid and the State Department of Health shall not certify more
1329 than thirty (30) of the beds in the facility for participation in
1330 the Medicaid program. If the facility violates the terms of the
1331 written agreement by admitting or keeping in the facility on a
1332 regular or continuing basis more than thirty (30) patients who are
1333 participating in the Medicaid program, the State Department of
1334 Health shall revoke the license of the facility, at the time that
1335 the department determines, after a hearing complying with due
1336 process, that the facility has violated the written agreement.

1337 (1) Provided that funds are specifically appropriated
1338 therefor by the Legislature, the department may issue a
1339 certificate of need to a rehabilitation hospital in Hinds County
1340 for the construction of a sixty-bed long-term care nursing
1341 facility dedicated to the care and treatment of persons with
1342 severe disabilities including persons with spinal cord and
1343 closed-head injuries and ventilator-dependent patients. The
1344 provision of Section 41-7-193(1) regarding substantial compliance
1345 with projection of need as reported in the current State Health
1346 Plan is hereby waived for the purpose of this paragraph.

1347 (m) The State Department of Health may issue a
1348 certificate of need to a county-owned hospital in the Second
1349 Judicial District of Panola County for the conversion of not more
1350 than seventy-two (72) hospital beds to nursing facility beds,
1351 provided that the recipient of the certificate of need agrees in
1352 writing that none of the beds at the nursing facility will be
1353 certified for participation in the Medicaid program (Section
1354 43-13-101 et seq.), and that no claim will be submitted for
1355 Medicaid reimbursement in the nursing facility in any day or for
1356 any patient in the nursing facility. This written agreement by
1357 the recipient of the certificate of need shall be a condition of



1358 the issuance of the certificate of need under this paragraph, and
1359 the agreement shall be fully binding on any subsequent owner of
1360 the nursing facility if the ownership of the nursing facility is
1361 transferred at any time after the issuance of the certificate of
1362 need. After this written agreement is executed, the Division of
1363 Medicaid and the State Department of Health shall not certify any
1364 of the beds in the nursing facility for participation in the
1365 Medicaid program. If the nursing facility violates the terms of
1366 the written agreement by admitting or keeping in the nursing
1367 facility on a regular or continuing basis any patients who are
1368 participating in the Medicaid program, the State Department of
1369 Health shall revoke the license of the nursing facility, at the
1370 time that the department determines, after a hearing complying
1371 with due process, that the nursing facility has violated the
1372 condition upon which the certificate of need was issued, as
1373 provided in this paragraph and in the written agreement. If the
1374 certificate of need authorized under this paragraph is not issued
1375 within twelve (12) months after July 1, 2001, the department shall
1376 deny the application for the certificate of need and shall not
1377 issue the certificate of need at any time after the twelve-month
1378 period, unless the issuance is contested. If the certificate of
1379 need is issued and substantial construction of the nursing
1380 facility beds has not commenced within eighteen (18) months after
1381 July 1, 2001, the State Department of Health, after a hearing
1382 complying with due process, shall revoke the certificate of need
1383 if it is still outstanding, and the department shall not issue a
1384 license for the nursing facility at any time after the
1385 eighteen-month period. Provided, however, that if the issuance of
1386 the certificate of need is contested, the department shall require
1387 substantial construction of the nursing facility beds within six
1388 (6) months after final adjudication on the issuance of the
1389 certificate of need.



1390 (n) The department may issue a certificate of need for
1391 the new construction, addition or conversion of skilled nursing
1392 facility beds in Madison County, provided that the recipient of
1393 the certificate of need agrees in writing that the skilled nursing
1394 facility will not at any time participate in the Medicaid program
1395 (Section 43-13-101 et seq.) or admit or keep any patients in the
1396 skilled nursing facility who are participating in the Medicaid
1397 program. This written agreement by the recipient of the
1398 certificate of need shall be fully binding on any subsequent owner
1399 of the skilled nursing facility, if the ownership of the facility
1400 is transferred at any time after the issuance of the certificate
1401 of need. Agreement that the skilled nursing facility will not
1402 participate in the Medicaid program shall be a condition of the
1403 issuance of a certificate of need to any person under this
1404 paragraph (n), and if such skilled nursing facility at any time
1405 after the issuance of the certificate of need, regardless of the
1406 ownership of the facility, participates in the Medicaid program or
1407 admits or keeps any patients in the facility who are participating
1408 in the Medicaid program, the State Department of Health shall
1409 revoke the certificate of need, if it is still outstanding, and
1410 shall deny or revoke the license of the skilled nursing facility,
1411 at the time that the department determines, after a hearing
1412 complying with due process, that the facility has failed to comply
1413 with any of the conditions upon which the certificate of need was
1414 issued, as provided in this paragraph and in the written agreement
1415 by the recipient of the certificate of need. The total number of
1416 nursing facility beds that may be authorized by any certificate of
1417 need issued under this paragraph (n) shall not exceed sixty (60)
1418 beds. If the certificate of need authorized under this paragraph
1419 is not issued within twelve (12) months after July 1, 1998, the
1420 department shall deny the application for the certificate of need
1421 and shall not issue the certificate of need at any time after the
1422 twelve-month period, unless the issuance is contested. If the



1423 certificate of need is issued and substantial construction of the
1424 nursing facility beds has not commenced within eighteen (18)
1425 months after the effective date of July 1, 1998, the State
1426 Department of Health, after a hearing complying with due process,
1427 shall revoke the certificate of need if it is still outstanding,
1428 and the department shall not issue a license for the nursing
1429 facility at any time after the eighteen-month period. Provided,
1430 however, that if the issuance of the certificate of need is
1431 contested, the department shall require substantial construction
1432 of the nursing facility beds within six (6) months after final
1433 adjudication on the issuance of the certificate of need.

1434 (o) The department may issue a certificate of need for
1435 the new construction, addition or conversion of skilled nursing
1436 facility beds in Leake County, provided that the recipient of the
1437 certificate of need agrees in writing that the skilled nursing
1438 facility will not at any time participate in the Medicaid program
1439 (Section 43-13-101 et seq.) or admit or keep any patients in the
1440 skilled nursing facility who are participating in the Medicaid
1441 program. This written agreement by the recipient of the
1442 certificate of need shall be fully binding on any subsequent owner
1443 of the skilled nursing facility, if the ownership of the facility
1444 is transferred at any time after the issuance of the certificate
1445 of need. Agreement that the skilled nursing facility will not
1446 participate in the Medicaid program shall be a condition of the
1447 issuance of a certificate of need to any person under this
1448 paragraph (o), and if such skilled nursing facility at any time
1449 after the issuance of the certificate of need, regardless of the
1450 ownership of the facility, participates in the Medicaid program or
1451 admits or keeps any patients in the facility who are participating
1452 in the Medicaid program, the State Department of Health shall
1453 revoke the certificate of need, if it is still outstanding, and
1454 shall deny or revoke the license of the skilled nursing facility,
1455 at the time that the department determines, after a hearing



1456 complying with due process, that the facility has failed to comply
1457 with any of the conditions upon which the certificate of need was
1458 issued, as provided in this paragraph and in the written agreement
1459 by the recipient of the certificate of need. The total number of
1460 nursing facility beds that may be authorized by any certificate of
1461 need issued under this paragraph (o) shall not exceed sixty (60)
1462 beds. If the certificate of need authorized under this paragraph
1463 is not issued within twelve (12) months after July 1, 2001, the
1464 department shall deny the application for the certificate of need
1465 and shall not issue the certificate of need at any time after the
1466 twelve-month period, unless the issuance is contested. If the
1467 certificate of need is issued and substantial construction of the
1468 nursing facility beds has not commenced within eighteen (18)
1469 months after the effective date of July 1, 2001, the State
1470 Department of Health, after a hearing complying with due process,
1471 shall revoke the certificate of need if it is still outstanding,
1472 and the department shall not issue a license for the nursing
1473 facility at any time after the eighteen-month period. Provided,
1474 however, that if the issuance of the certificate of need is
1475 contested, the department shall require substantial construction
1476 of the nursing facility beds within six (6) months after final
1477 adjudication on the issuance of the certificate of need.

1478 (p) The department may issue a certificate of need for
1479 the construction of a municipally-owned nursing facility within
1480 the Town of Belmont in Tishomingo County, not to exceed sixty (60)
1481 beds, provided that the recipient of the certificate of need
1482 agrees in writing that the skilled nursing facility will not at
1483 any time participate in the Medicaid program (Section 43-13-101 et
1484 seq.) or admit or keep any patients in the skilled nursing
1485 facility who are participating in the Medicaid program. This
1486 written agreement by the recipient of the certificate of need
1487 shall be fully binding on any subsequent owner of the skilled
1488 nursing facility, if the ownership of the facility is transferred



1489 at any time after the issuance of the certificate of need.
1490 Agreement that the skilled nursing facility will not participate
1491 in the Medicaid program shall be a condition of the issuance of a
1492 certificate of need to any person under this paragraph (p), and if
1493 such skilled nursing facility at any time after the issuance of
1494 the certificate of need, regardless of the ownership of the
1495 facility, participates in the Medicaid program or admits or keeps
1496 any patients in the facility who are participating in the Medicaid
1497 program, the State Department of Health shall revoke the
1498 certificate of need, if it is still outstanding, and shall deny or
1499 revoke the license of the skilled nursing facility, at the time
1500 that the department determines, after a hearing complying with due
1501 process, that the facility has failed to comply with any of the
1502 conditions upon which the certificate of need was issued, as
1503 provided in this paragraph and in the written agreement by the
1504 recipient of the certificate of need. The provision of Section
1505 43-7-193(1) regarding substantial compliance of the projection of
1506 need as reported in the current State Health Plan is waived for
1507 the purposes of this paragraph. If the certificate of need
1508 authorized under this paragraph is not issued within twelve (12)
1509 months after July 1, 1998, the department shall deny the
1510 application for the certificate of need and shall not issue the
1511 certificate of need at any time after the twelve-month period,
1512 unless the issuance is contested. If the certificate of need is
1513 issued and substantial construction of the nursing facility beds
1514 has not commenced within eighteen (18) months after July 1, 1998,
1515 the State Department of Health, after a hearing complying with due
1516 process, shall revoke the certificate of need if it is still
1517 outstanding, and the department shall not issue a license for the
1518 nursing facility at any time after the eighteen-month period.
1519 Provided, however, that if the issuance of the certificate of need
1520 is contested, the department shall require substantial
1521 construction of the nursing facility beds within six (6) months



1522 after final adjudication on the issuance of the certificate of
1523 need.

1524 (q) (i) Beginning on July 1, 1999, the State
1525 Department of Health shall issue certificates of need during each
1526 of the next four (4) fiscal years for the construction or
1527 expansion of nursing facility beds or the conversion of other beds
1528 to nursing facility beds in each county in the state having a need
1529 for fifty (50) or more additional nursing facility beds, as shown
1530 in the fiscal year 1999 State Health Plan, in the manner provided
1531 in this paragraph (q). The total number of nursing facility beds
1532 that may be authorized by any certificate of need authorized under
1533 this paragraph (q) shall not exceed sixty (60) beds.

1534 (ii) Subject to the provisions of subparagraph
1535 (v), during each of the next four (4) fiscal years, the department
1536 shall issue six (6) certificates of need for new nursing facility
1537 beds, as follows: During fiscal years 2000, 2001 and 2002, one
1538 (1) certificate of need shall be issued for new nursing facility
1539 beds in the county in each of the four (4) Long-Term Care Planning
1540 Districts designated in the fiscal year 1999 State Health Plan
1541 that has the highest need in the district for those beds; and two
1542 (2) certificates of need shall be issued for new nursing facility
1543 beds in the two (2) counties from the state at large that have the
1544 highest need in the state for those beds, when considering the
1545 need on a statewide basis and without regard to the Long-Term Care
1546 Planning Districts in which the counties are located. During
1547 fiscal year 2003, one (1) certificate of need shall be issued for
1548 new nursing facility beds in any county having a need for fifty
1549 (50) or more additional nursing facility beds, as shown in the
1550 fiscal year 1999 State Health Plan, that has not received a
1551 certificate of need under this paragraph (q) during the three (3)
1552 previous fiscal years. During fiscal year 2000, in addition to
1553 the six (6) certificates of need authorized in this subparagraph,
1554 the department also shall issue a certificate of need for new



1555 nursing facility beds in Amite County and a certificate of need
1556 for new nursing facility beds in Carroll County.

1557 (iii) Subject to the provisions of subparagraph
1558 (v), the certificate of need issued under subparagraph (ii) for
1559 nursing facility beds in each Long-Term Care Planning District
1560 during each fiscal year shall first be available for nursing
1561 facility beds in the county in the district having the highest
1562 need for those beds, as shown in the fiscal year 1999 State Health
1563 Plan. If there are no applications for a certificate of need for
1564 nursing facility beds in the county having the highest need for
1565 those beds by the date specified by the department, then the
1566 certificate of need shall be available for nursing facility beds
1567 in other counties in the district in descending order of the need
1568 for those beds, from the county with the second highest need to
1569 the county with the lowest need, until an application is received
1570 for nursing facility beds in an eligible county in the district.

1571 (iv) Subject to the provisions of subparagraph
1572 (v), the certificate of need issued under subparagraph (ii) for
1573 nursing facility beds in the two (2) counties from the state at
1574 large during each fiscal year shall first be available for nursing
1575 facility beds in the two (2) counties that have the highest need
1576 in the state for those beds, as shown in the fiscal year 1999
1577 State Health Plan, when considering the need on a statewide basis
1578 and without regard to the Long-Term Care Planning Districts in
1579 which the counties are located. If there are no applications for
1580 a certificate of need for nursing facility beds in either of the
1581 two (2) counties having the highest need for those beds on a
1582 statewide basis by the date specified by the department, then the
1583 certificate of need shall be available for nursing facility beds
1584 in other counties from the state at large in descending order of
1585 the need for those beds on a statewide basis, from the county with
1586 the second highest need to the county with the lowest need, until



1587 an application is received for nursing facility beds in an
1588 eligible county from the state at large.

1589 (v) If a certificate of need is authorized to be
1590 issued under this paragraph (q) for nursing facility beds in a
1591 county on the basis of the need in the Long-Term Care Planning
1592 District during any fiscal year of the four-year period, a
1593 certificate of need shall not also be available under this
1594 paragraph (q) for additional nursing facility beds in that county
1595 on the basis of the need in the state at large, and that county
1596 shall be excluded in determining which counties have the highest
1597 need for nursing facility beds in the state at large for that
1598 fiscal year. After a certificate of need has been issued under
1599 this paragraph (q) for nursing facility beds in a county during
1600 any fiscal year of the four-year period, a certificate of need
1601 shall not be available again under this paragraph (q) for
1602 additional nursing facility beds in that county during the
1603 four-year period, and that county shall be excluded in determining
1604 which counties have the highest need for nursing facility beds in
1605 succeeding fiscal years.

1606 (vi) If more than one (1) application is made for
1607 a certificate of need for nursing home facility beds available
1608 under this paragraph (q), in Yalobusha, Newton or Tallahatchie
1609 County, and one (1) of the applicants is a county-owned hospital
1610 located in the county where the nursing facility beds are
1611 available, the department shall give priority to the county-owned
1612 hospital in granting the certificate of need if the following
1613 conditions are met:

1614 1. The county-owned hospital fully meets all
1615 applicable criteria and standards required to obtain a certificate
1616 of need for the nursing facility beds; and

1617 2. The county-owned hospital's qualifications
1618 for the certificate of need, as shown in its application and as
1619 determined by the department, are at least equal to the



1620 qualifications of the other applicants for the certificate of
1621 need.

1622 (r) (i) Beginning on July 1, 1999, the State
1623 Department of Health shall issue certificates of need during each
1624 of the next two (2) fiscal years for the construction or expansion
1625 of nursing facility beds or the conversion of other beds to
1626 nursing facility beds in each of the four (4) Long-Term Care
1627 Planning Districts designated in the fiscal year 1999 State Health
1628 Plan, to provide care exclusively to patients with Alzheimer's
1629 disease.

1630 (ii) Not more than twenty (20) beds may be
1631 authorized by any certificate of need issued under this paragraph
1632 (r), and not more than a total of sixty (60) beds may be
1633 authorized in any Long-Term Care Planning District by all
1634 certificates of need issued under this paragraph (r). However,
1635 the total number of beds that may be authorized by all
1636 certificates of need issued under this paragraph (r) during any
1637 fiscal year shall not exceed one hundred twenty (120) beds, and
1638 the total number of beds that may be authorized in any Long-Term
1639 Care Planning District during any fiscal year shall not exceed
1640 forty (40) beds. Of the certificates of need that are issued for
1641 each Long-Term Care Planning District during the next two (2)
1642 fiscal years, at least one (1) shall be issued for beds in the
1643 northern part of the district, at least one (1) shall be issued
1644 for beds in the central part of the district, and at least one (1)
1645 shall be issued for beds in the southern part of the district.

1646 (iii) The State Department of Health, in
1647 consultation with the Department of Mental Health and the Division
1648 of Medicaid, shall develop and prescribe the staffing levels,
1649 space requirements and other standards and requirements that must
1650 be met with regard to the nursing facility beds authorized under
1651 this paragraph (r) to provide care exclusively to patients with
1652 Alzheimer's disease.



1653 (3) The State Department of Health may grant approval for
1654 and issue certificates of need to any person proposing the new
1655 construction of, addition to, conversion of beds of or expansion
1656 of any health care facility defined in subparagraph (x)
1657 (psychiatric residential treatment facility) of Section
1658 41-7-173(h). The total number of beds which may be authorized by
1659 such certificates of need shall not exceed three hundred
1660 thirty-four (334) beds for the entire state.

1661 (a) Of the total number of beds authorized under this
1662 subsection, the department shall issue a certificate of need to a
1663 privately owned psychiatric residential treatment facility in
1664 Simpson County for the conversion of sixteen (16) intermediate
1665 care facility for the mentally retarded (ICF-MR) beds to
1666 psychiatric residential treatment facility beds, provided that
1667 facility agrees in writing that the facility shall give priority
1668 for the use of those sixteen (16) beds to Mississippi residents
1669 who are presently being treated in out-of-state facilities.

1670 (b) Of the total number of beds authorized under this
1671 subsection, the department may issue a certificate or certificates
1672 of need for the construction or expansion of psychiatric
1673 residential treatment facility beds or the conversion of other
1674 beds to psychiatric residential treatment facility beds in Warren
1675 County, not to exceed sixty (60) psychiatric residential treatment
1676 facility beds, provided that the facility agrees in writing that
1677 no more than thirty (30) of the beds at the psychiatric
1678 residential treatment facility will be certified for participation
1679 in the Medicaid program (Section 43-13-101 et seq.) for the use of
1680 any patients other than those who are participating only in the
1681 Medicaid program of another state, and that no claim will be
1682 submitted to the Division of Medicaid for Medicaid reimbursement
1683 for more than thirty (30) patients in the psychiatric residential
1684 treatment facility in any day or for any patient in the
1685 psychiatric residential treatment facility who is in a bed that is



1686 not Medicaid-certified. This written agreement by the recipient
1687 of the certificate of need shall be a condition of the issuance of
1688 the certificate of need under this paragraph, and the agreement
1689 shall be fully binding on any subsequent owner of the psychiatric
1690 residential treatment facility if the ownership of the facility is
1691 transferred at any time after the issuance of the certificate of
1692 need. After this written agreement is executed, the Division of
1693 Medicaid and the State Department of Health shall not certify more
1694 than thirty (30) of the beds in the psychiatric residential
1695 treatment facility for participation in the Medicaid program for
1696 the use of any patients other than those who are participating
1697 only in the Medicaid program of another state. If the psychiatric
1698 residential treatment facility violates the terms of the written
1699 agreement by admitting or keeping in the facility on a regular or
1700 continuing basis more than thirty (30) patients who are
1701 participating in the Mississippi Medicaid program, the State
1702 Department of Health shall revoke the license of the facility, at
1703 the time that the department determines, after a hearing complying
1704 with due process, that the facility has violated the condition
1705 upon which the certificate of need was issued, as provided in this
1706 paragraph and in the written agreement.

1707 If by January 1, 2002, there has been no significant
1708 commencement of construction of the beds authorized under this
1709 paragraph (b), or no significant action taken to convert existing
1710 beds to the beds authorized under this paragraph, then the
1711 certificate of need that was previously issued under this
1712 paragraph shall expire. If the previously issued certificate of
1713 need expires, the department may accept applications for issuance
1714 of another certificate of need for the beds authorized under this
1715 paragraph, and may issue a certificate of need to authorize the
1716 construction, expansion or conversion of the beds authorized under
1717 this paragraph.



1718 (c) Of the total number of beds authorized under this
1719 subsection, the department shall issue a certificate of need to a
1720 hospital currently operating Medicaid-certified acute psychiatric
1721 beds for adolescents in DeSoto County, for the establishment of a
1722 forty-bed psychiatric residential treatment facility in DeSoto
1723 County, provided that the hospital agrees in writing (i) that the
1724 hospital shall give priority for the use of those forty (40) beds
1725 to Mississippi residents who are presently being treated in
1726 out-of-state facilities, and (ii) that no more than fifteen (15)
1727 of the beds at the psychiatric residential treatment facility will
1728 be certified for participation in the Medicaid program (Section
1729 43-13-101 et seq.), and that no claim will be submitted for
1730 Medicaid reimbursement for more than fifteen (15) patients in the
1731 psychiatric residential treatment facility in any day or for any
1732 patient in the psychiatric residential treatment facility who is
1733 in a bed that is not Medicaid-certified. This written agreement
1734 by the recipient of the certificate of need shall be a condition
1735 of the issuance of the certificate of need under this paragraph,
1736 and the agreement shall be fully binding on any subsequent owner
1737 of the psychiatric residential treatment facility if the ownership
1738 of the facility is transferred at any time after the issuance of
1739 the certificate of need. After this written agreement is
1740 executed, the Division of Medicaid and the State Department of
1741 Health shall not certify more than fifteen (15) of the beds in the
1742 psychiatric residential treatment facility for participation in
1743 the Medicaid program. If the psychiatric residential treatment
1744 facility violates the terms of the written agreement by admitting
1745 or keeping in the facility on a regular or continuing basis more
1746 than fifteen (15) patients who are participating in the Medicaid
1747 program, the State Department of Health shall revoke the license
1748 of the facility, at the time that the department determines, after
1749 a hearing complying with due process, that the facility has
1750 violated the condition upon which the certificate of need was



1751 issued, as provided in this paragraph and in the written
1752 agreement.

1753 (d) Of the total number of beds authorized under this
1754 subsection, the department may issue a certificate or certificates
1755 of need for the construction or expansion of psychiatric
1756 residential treatment facility beds or the conversion of other
1757 beds to psychiatric treatment facility beds, not to exceed thirty
1758 (30) psychiatric residential treatment facility beds, in either
1759 Alcorn, Tishomingo, Prentiss, Lee, Itawamba, Monroe, Chickasaw,
1760 Pontotoc, Calhoun, Lafayette, Union, Benton or Tippah Counties.

1761 (e) Of the total number of beds authorized under this
1762 subsection (3) the department shall issue a certificate of need to
1763 a privately owned, nonprofit psychiatric residential treatment
1764 facility in Hinds County for an eight-bed expansion of the
1765 facility, provided that the facility agrees in writing that the
1766 facility shall give priority for the use of those eight (8) beds
1767 to Mississippi residents who are presently being treated in
1768 out-of-state facilities.

1769 (f) The department shall issue a certificate of need to
1770 a one-hundred-thirty-four-bed specialty hospital located on
1771 twenty-nine and forty-four one-hundredths (29.44) commercial acres
1772 at 5900 Highway 39 North in Meridian (Lauderdale County),
1773 Mississippi, for the addition, construction or expansion of
1774 child/adolescent psychiatric residential treatment facility beds
1775 in Lauderdale County. As a condition of issuance of the
1776 certificate of need under this paragraph, the facility shall give
1777 priority in admissions to the child/adolescent psychiatric
1778 residential treatment facility beds authorized under this
1779 paragraph to patients who otherwise would require out-of-state
1780 placement. * * * For purposes of this paragraph, the provisions
1781 of Section 41-7-193(1) requiring substantial compliance with the
1782 projection of need as reported in the current State Health Plan
1783 are waived. The total number of child/adolescent psychiatric



1784 residential treatment facility beds that may be authorized under
1785 the authority of this paragraph shall be sixty (60) beds. There
1786 shall be no prohibition or restrictions on participation in the
1787 Medicaid program (Section 43-13-101 et seq.) for the person
1788 receiving the certificate of need authorized under this paragraph
1789 or for the beds converted pursuant to the authority of that
1790 certificate of need.

1791 (4) (a) From and after July 1, 1993, the department shall
1792 not issue a certificate of need to any person for the new
1793 construction of any hospital, psychiatric hospital or chemical
1794 dependency hospital that will contain any child/adolescent
1795 psychiatric or child/adolescent chemical dependency beds, or for
1796 the conversion of any other health care facility to a hospital,
1797 psychiatric hospital or chemical dependency hospital that will
1798 contain any child/adolescent psychiatric or child/adolescent
1799 chemical dependency beds, or for the addition of any
1800 child/adolescent psychiatric or child/adolescent chemical
1801 dependency beds in any hospital, psychiatric hospital or chemical
1802 dependency hospital, or for the conversion of any beds of another
1803 category in any hospital, psychiatric hospital or chemical
1804 dependency hospital to child/adolescent psychiatric or
1805 child/adolescent chemical dependency beds, except as hereinafter
1806 authorized:

1807 (i) The department may issue certificates of need
1808 to any person for any purpose described in this subsection,
1809 provided that the hospital, psychiatric hospital or chemical
1810 dependency hospital does not participate in the Medicaid program
1811 (Section 43-13-101 et seq.) at the time of the application for the
1812 certificate of need and the owner of the hospital, psychiatric
1813 hospital or chemical dependency hospital agrees in writing that
1814 the hospital, psychiatric hospital or chemical dependency hospital
1815 will not at any time participate in the Medicaid program or admit
1816 or keep any patients who are participating in the Medicaid program



1817 in the hospital, psychiatric hospital or chemical dependency
1818 hospital. This written agreement by the recipient of the
1819 certificate of need shall be fully binding on any subsequent owner
1820 of the hospital, psychiatric hospital or chemical dependency
1821 hospital, if the ownership of the facility is transferred at any
1822 time after the issuance of the certificate of need. Agreement
1823 that the hospital, psychiatric hospital or chemical dependency
1824 hospital will not participate in the Medicaid program shall be a
1825 condition of the issuance of a certificate of need to any person
1826 under this subparagraph (a)(i), and if such hospital, psychiatric
1827 hospital or chemical dependency hospital at any time after the
1828 issuance of the certificate of need, regardless of the ownership
1829 of the facility, participates in the Medicaid program or admits or
1830 keeps any patients in the hospital, psychiatric hospital or
1831 chemical dependency hospital who are participating in the Medicaid
1832 program, the State Department of Health shall revoke the
1833 certificate of need, if it is still outstanding, and shall deny or
1834 revoke the license of the hospital, psychiatric hospital or
1835 chemical dependency hospital, at the time that the department
1836 determines, after a hearing complying with due process, that the
1837 hospital, psychiatric hospital or chemical dependency hospital has
1838 failed to comply with any of the conditions upon which the
1839 certificate of need was issued, as provided in this subparagraph
1840 and in the written agreement by the recipient of the certificate
1841 of need.

1842 (ii) The department may issue a certificate of
1843 need for the conversion of existing beds in a county hospital in
1844 Choctaw County from acute care beds to child/adolescent chemical
1845 dependency beds. For purposes of this subparagraph, the
1846 provisions of Section 41-7-193(1) requiring substantial compliance
1847 with the projection of need as reported in the current State
1848 Health Plan is waived. The total number of beds that may be
1849 authorized under authority of this subparagraph shall not exceed



1850 twenty (20) beds. There shall be no prohibition or restrictions
1851 on participation in the Medicaid program (Section 43-13-101 et
1852 seq.) for the hospital receiving the certificate of need
1853 authorized under this subparagraph (a)(ii) or for the beds
1854 converted pursuant to the authority of that certificate of need.

1855 (iii) The department may issue a certificate or
1856 certificates of need for the construction or expansion of
1857 child/adolescent psychiatric beds or the conversion of other beds
1858 to child/adolescent psychiatric beds in Warren County. For
1859 purposes of this subparagraph, the provisions of Section
1860 41-7-193(1) requiring substantial compliance with the projection
1861 of need as reported in the current State Health Plan are waived.
1862 The total number of beds that may be authorized under the
1863 authority of this subparagraph shall not exceed twenty (20) beds.
1864 There shall be no prohibition or restrictions on participation in
1865 the Medicaid program (Section 43-13-101 et seq.) for the person
1866 receiving the certificate of need authorized under this
1867 subparagraph (a)(iii) or for the beds converted pursuant to the
1868 authority of that certificate of need.

1869 If by January 1, 2002, there has been no significant
1870 commencement of construction of the beds authorized under this
1871 subparagraph (a)(iii), or no significant action taken to convert
1872 existing beds to the beds authorized under this subparagraph, then
1873 the certificate of need that was previously issued under this
1874 subparagraph shall expire. If the previously issued certificate
1875 of need expires, the department may accept applications for
1876 issuance of another certificate of need for the beds authorized
1877 under this subparagraph, and may issue a certificate of need to
1878 authorize the construction, expansion or conversion of the beds
1879 authorized under this subparagraph.

1880 (iv) The department shall issue a certificate of
1881 need to the Region 7 Mental Health/Retardation Commission for the
1882 construction or expansion of child/adolescent psychiatric beds or



1883 the conversion of other beds to child/adolescent psychiatric beds
1884 in any of the counties served by the commission. For purposes of
1885 this subparagraph, the provisions of Section 41-7-193(1) requiring
1886 substantial compliance with the projection of need as reported in
1887 the current State Health Plan is waived. The total number of beds
1888 that may be authorized under the authority of this subparagraph
1889 shall not exceed twenty (20) beds. There shall be no prohibition
1890 or restrictions on participation in the Medicaid program (Section
1891 43-13-101 et seq.) for the person receiving the certificate of
1892 need authorized under this subparagraph (a)(iv) or for the beds
1893 converted pursuant to the authority of that certificate of need.

1894 (v) The department may issue a certificate of need
1895 to any county hospital located in Leflore County for the
1896 construction or expansion of adult psychiatric beds or the
1897 conversion of other beds to adult psychiatric beds, not to exceed
1898 twenty (20) beds, provided that the recipient of the certificate
1899 of need agrees in writing that the adult psychiatric beds will not
1900 at any time be certified for participation in the Medicaid program
1901 and that the hospital will not admit or keep any patients who are
1902 participating in the Medicaid program in any of such adult
1903 psychiatric beds. This written agreement by the recipient of the
1904 certificate of need shall be fully binding on any subsequent owner
1905 of the hospital if the ownership of the hospital is transferred at
1906 any time after the issuance of the certificate of need. Agreement
1907 that the adult psychiatric beds will not be certified for
1908 participation in the Medicaid program shall be a condition of the
1909 issuance of a certificate of need to any person under this
1910 subparagraph (a)(v), and if such hospital at any time after the
1911 issuance of the certificate of need, regardless of the ownership
1912 of the hospital, has any of such adult psychiatric beds certified
1913 for participation in the Medicaid program or admits or keeps any
1914 Medicaid patients in such adult psychiatric beds, the State
1915 Department of Health shall revoke the certificate of need, if it



1916 is still outstanding, and shall deny or revoke the license of the
1917 hospital at the time that the department determines, after a
1918 hearing complying with due process, that the hospital has failed
1919 to comply with any of the conditions upon which the certificate of
1920 need was issued, as provided in this subparagraph and in the
1921 written agreement by the recipient of the certificate of need.

1922 (vi) The department may issue a certificate or
1923 certificates of need for the expansion of child psychiatric beds
1924 or the conversion of other beds to child psychiatric beds at the
1925 University of Mississippi Medical Center. For purposes of this
1926 subparagraph (a)(vi), the provision of Section 41-7-193(1)
1927 requiring substantial compliance with the projection of need as
1928 reported in the current State Health Plan is waived. The total
1929 number of beds that may be authorized under the authority of this
1930 subparagraph (a)(vi) shall not exceed fifteen (15) beds. There
1931 shall be no prohibition or restrictions on participation in the
1932 Medicaid program (Section 43-13-101 et seq.) for the hospital
1933 receiving the certificate of need authorized under this
1934 subparagraph (a)(vi) or for the beds converted pursuant to the
1935 authority of that certificate of need.

1936 (b) From and after July 1, 1990, no hospital,
1937 psychiatric hospital or chemical dependency hospital shall be
1938 authorized to add any child/adolescent psychiatric or
1939 child/adolescent chemical dependency beds or convert any beds of
1940 another category to child/adolescent psychiatric or
1941 child/adolescent chemical dependency beds without a certificate of
1942 need under the authority of subsection (1)(c) of this section.

1943 (5) The department may issue a certificate of need to a
1944 county hospital in Winston County for the conversion of fifteen
1945 (15) acute care beds to geriatric psychiatric care beds.

1946 (6) The State Department of Health shall issue a certificate
1947 of need to a Mississippi corporation qualified to manage a
1948 long-term care hospital as defined in Section 41-7-173(h)(xii) in



1949 Harrison County, not to exceed eighty (80) beds, including any
1950 necessary renovation or construction required for licensure and
1951 certification, provided that the recipient of the certificate of
1952 need agrees in writing that the long-term care hospital will not
1953 at any time participate in the Medicaid program (Section 43-13-101
1954 et seq.) or admit or keep any patients in the long-term care
1955 hospital who are participating in the Medicaid program. This
1956 written agreement by the recipient of the certificate of need
1957 shall be fully binding on any subsequent owner of the long-term
1958 care hospital, if the ownership of the facility is transferred at
1959 any time after the issuance of the certificate of need. Agreement
1960 that the long-term care hospital will not participate in the
1961 Medicaid program shall be a condition of the issuance of a
1962 certificate of need to any person under this subsection (6), and
1963 if such long-term care hospital at any time after the issuance of
1964 the certificate of need, regardless of the ownership of the
1965 facility, participates in the Medicaid program or admits or keeps
1966 any patients in the facility who are participating in the Medicaid
1967 program, the State Department of Health shall revoke the
1968 certificate of need, if it is still outstanding, and shall deny or
1969 revoke the license of the long-term care hospital, at the time
1970 that the department determines, after a hearing complying with due
1971 process, that the facility has failed to comply with any of the
1972 conditions upon which the certificate of need was issued, as
1973 provided in this subsection and in the written agreement by the
1974 recipient of the certificate of need. For purposes of this
1975 subsection, the provision of Section 41-7-193(1) requiring
1976 substantial compliance with the projection of need as reported in
1977 the current State Health Plan is hereby waived.

1978 (7) The State Department of Health may issue a certificate
1979 of need to any hospital in the state to utilize a portion of its
1980 beds for the "swing-bed" concept. Any such hospital must be in
1981 conformance with the federal regulations regarding such swing-bed



1982 concept at the time it submits its application for a certificate
1983 of need to the State Department of Health, except that such
1984 hospital may have more licensed beds or a higher average daily
1985 census (ADC) than the maximum number specified in federal
1986 regulations for participation in the swing-bed program. Any
1987 hospital meeting all federal requirements for participation in the
1988 swing-bed program which receives such certificate of need shall
1989 render services provided under the swing-bed concept to any
1990 patient eligible for Medicare (Title XVIII of the Social Security
1991 Act) who is certified by a physician to be in need of such
1992 services, and no such hospital shall permit any patient who is
1993 eligible for both Medicaid and Medicare or eligible only for
1994 Medicaid to stay in the swing beds of the hospital for more than
1995 thirty (30) days per admission unless the hospital receives prior
1996 approval for such patient from the Division of Medicaid, Office of
1997 the Governor. Any hospital having more licensed beds or a higher
1998 average daily census (ADC) than the maximum number specified in
1999 federal regulations for participation in the swing-bed program
2000 which receives such certificate of need shall develop a procedure
2001 to insure that before a patient is allowed to stay in the swing
2002 beds of the hospital, there are no vacant nursing home beds
2003 available for that patient located within a fifty-mile radius of
2004 the hospital. When any such hospital has a patient staying in the
2005 swing beds of the hospital and the hospital receives notice from a
2006 nursing home located within such radius that there is a vacant bed
2007 available for that patient, the hospital shall transfer the
2008 patient to the nursing home within a reasonable time after receipt
2009 of the notice. Any hospital which is subject to the requirements
2010 of the two (2) preceding sentences of this subsection may be
2011 suspended from participation in the swing-bed program for a
2012 reasonable period of time by the State Department of Health if the
2013 department, after a hearing complying with due process, determines



2014 that the hospital has failed to comply with any of those
2015 requirements.

2016 (8) The Department of Health shall not grant approval for or
2017 issue a certificate of need to any person proposing the new
2018 construction of, addition to or expansion of a health care
2019 facility as defined in subparagraph (viii) of Section 41-7-173(h).

2020 (9) The Department of Health shall not grant approval for or
2021 issue a certificate of need to any person proposing the
2022 establishment of, or expansion of the currently approved territory
2023 of, or the contracting to establish a home office, subunit or
2024 branch office within the space operated as a health care facility
2025 as defined in Section 41-7-173(h) (i) through (viii) by a health
2026 care facility as defined in subparagraph (ix) of Section
2027 41-7-173(h).

2028 (10) Health care facilities owned and/or operated by the
2029 state or its agencies are exempt from the restraints in this
2030 section against issuance of a certificate of need if such addition
2031 or expansion consists of repairing or renovation necessary to
2032 comply with the state licensure law. This exception shall not
2033 apply to the new construction of any building by such state
2034 facility. This exception shall not apply to any health care
2035 facilities owned and/or operated by counties, municipalities,
2036 districts, unincorporated areas, other defined persons, or any
2037 combination thereof.

2038 (11) The new construction, renovation or expansion of or
2039 addition to any health care facility defined in subparagraph (ii)
2040 (psychiatric hospital), subparagraph (iv) (skilled nursing
2041 facility), subparagraph (vi) (intermediate care facility),
2042 subparagraph (viii) (intermediate care facility for the mentally
2043 retarded) and subparagraph (x) (psychiatric residential treatment
2044 facility) of Section 41-7-173(h) which is owned by the State of
2045 Mississippi and under the direction and control of the State
2046 Department of Mental Health, and the addition of new beds or the



2047 conversion of beds from one category to another in any such
2048 defined health care facility which is owned by the State of
2049 Mississippi and under the direction and control of the State
2050 Department of Mental Health, shall not require the issuance of a
2051 certificate of need under Section 41-7-171 et seq.,
2052 notwithstanding any provision in Section 41-7-171 et seq. to the
2053 contrary.

2054 (12) The new construction, renovation or expansion of or
2055 addition to any veterans homes or domiciliaries for eligible
2056 veterans of the State of Mississippi as authorized under Section
2057 35-1-19 shall not require the issuance of a certificate of need,
2058 notwithstanding any provision in Section 41-7-171 et seq. to the
2059 contrary.

2060 (13) The new construction of a nursing facility or nursing
2061 facility beds or the conversion of other beds to nursing facility
2062 beds shall not require the issuance of a certificate of need,
2063 notwithstanding any provision in Section 41-7-171 et seq. to the
2064 contrary, if the conditions of this subsection are met.

2065 (a) Before any construction or conversion may be
2066 undertaken without a certificate of need, the owner of the nursing
2067 facility, in the case of an existing facility, or the applicant to
2068 construct a nursing facility, in the case of new construction,
2069 first must file a written notice of intent and sign a written
2070 agreement with the State Department of Health that the entire
2071 nursing facility will not at any time participate in or have any
2072 beds certified for participation in the Medicaid program (Section
2073 43-13-101 et seq.), will not admit or keep any patients in the
2074 nursing facility who are participating in the Medicaid program,
2075 and will not submit any claim for Medicaid reimbursement for any
2076 patient in the facility. This written agreement by the owner or
2077 applicant shall be a condition of exercising the authority under
2078 this subsection without a certificate of need, and the agreement
2079 shall be fully binding on any subsequent owner of the nursing



2080 facility if the ownership of the facility is transferred at any
2081 time after the agreement is signed. After the written agreement
2082 is signed, the Division of Medicaid and the State Department of
2083 Health shall not certify any beds in the nursing facility for
2084 participation in the Medicaid program. If the nursing facility
2085 violates the terms of the written agreement by participating in
2086 the Medicaid program, having any beds certified for participation
2087 in the Medicaid program, admitting or keeping any patient in the
2088 facility who is participating in the Medicaid program, or
2089 submitting any claim for Medicaid reimbursement for any patient in
2090 the facility, the State Department of Health shall revoke the
2091 license of the nursing facility at the time that the department
2092 determines, after a hearing complying with due process, that the
2093 facility has violated the terms of the written agreement.

2094 (b) For the purposes of this subsection, participation
2095 in the Medicaid program by a nursing facility includes Medicaid
2096 reimbursement of coinsurance and deductibles for recipients who
2097 are qualified Medicare beneficiaries and/or those who are dually
2098 eligible. Any nursing facility exercising the authority under
2099 this subsection may not bill or submit a claim to the Division of
2100 Medicaid for services to qualified Medicare beneficiaries and/or
2101 those who are dually eligible.

2102 (c) The new construction of a nursing facility or
2103 nursing facility beds or the conversion of other beds to nursing
2104 facility beds described in this section must be either a part of a
2105 completely new continuing care retirement community, as described
2106 in the latest edition of the Mississippi State Health Plan, or an
2107 addition to existing personal care and independent living
2108 components, and so that the completed project will be a continuing
2109 care retirement community, containing (i) independent living
2110 accommodations, (ii) personal care beds, and (iii) the nursing
2111 home facility beds. The three (3) components must be located on a
2112 single site and be operated as one (1) inseparable facility. The



2113 nursing facility component must contain a minimum of thirty (30)
2114 beds. Any nursing facility beds authorized by this section will
2115 not be counted against the bed need set forth in the State Health
2116 Plan, as identified in Section 41-7-171, et seq.

2117 This subsection (13) shall stand repealed from and after July
2118 1, 2005.

2119 (14) The State Department of Health shall issue a
2120 certificate of need to any hospital which is currently licensed
2121 for two hundred fifty (250) or more acute care beds and is located
2122 in any general hospital service area not having a comprehensive
2123 cancer center, for the establishment and equipping of such a
2124 center which provides facilities and services for outpatient
2125 radiation oncology therapy, outpatient medical oncology therapy,
2126 and appropriate support services including the provision of
2127 radiation therapy services. The provision of Section 41-7-193(1)
2128 regarding substantial compliance with the projection of need as
2129 reported in the current State Health Plan is waived for the
2130 purpose of this subsection.

2131 (15) The State Department of Health may authorize the
2132 transfer of hospital beds, not to exceed sixty (60) beds, from the
2133 North Panola Community Hospital to the South Panola Community
2134 Hospital. The authorization for the transfer of those beds shall
2135 be exempt from the certificate of need review process.

2136 (16) Nothing in this section or in any other provision of
2137 Section 41-7-171 et seq. shall prevent any nursing facility from
2138 designating an appropriate number of existing beds in the facility
2139 as beds for providing care exclusively to patients with
2140 Alzheimer's disease.

2141 **SECTION 6.** This act shall take effect and be in force from
2142 and after its passage.

