MISSISSIPPI LEGISLATURE

REGULAR SESSION 2002

By: Senator(s) Bryan

To: Public Health and Welfare; Appropriations

SENATE BILL NO. 2739

AN ACT ENTITLED THE "MISSISSIPPIANS' ACCESS TO HEALTHCARE ACT OF 2002"; TO AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972, TO DIRECT THE DIVISION OF MEDICAID TO APPLY FOR A FEDERAL 1115 WAIVER FOR A PHARMACEUTICAL DRUG PROGRAM FOR NEEDY SENIORS; TO DIRECT THE DIVISION OF MEDICAID TO APPLY FOR A FEDERAL 1115 WAIVER FOR A DIABETES CASE MANAGEMENT PROGRAM FOR THE UNINSURED AND UNDER-INSURED; TO DIRECT THE DIVISION OF MEDICAID TO APPLY FOR A FEDERAL 1115 WAIVER FOR A CARDIOVASCULAR DISEASE CASE MANAGEMENT PROGRAM FOR THE UNINSURED AND UNDER-INSURED; TO DIRECT THE DIVISION OF MEDICAID TO APPLY FOR A FEDERAL 1115 WAIVER FOR A BREAST AND CERVICAL CANCER PREVENTION PROGRAM FOR WOMEN AGE 40-50 AND OTHER HIGH-RISK INDIVIDUALS; TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO DIRECT THE DIVISION OF MEDICAID TO APPLY FOR A FEDERAL 1115 WAIVER TO PROVIDE SCHOOL NURSE SERVICES TO ALL SCHOOL-AGE CHILDREN; TO AUTHORIZE THE DIVISION OF MEDICAID TO ESTABLISH MEDICARE RATE REIMBURSEMENT FOR INPATIENT AND OUTPATIENT SERVICES AT CRITICAL ACCESS HOSPITALS; TO AMEND SECTION 25-15-9, MISSISSIPPI CODE OF 1972, TO REMOVE THE DEDUCTIBLE FOR NETWORK PHYSICIAN OFFICE VISITS BY THE EMPLOYEE OR A DEPENDENT, APPLY A CO-PAY FOR A PHYSICIAN VISIT, AND APPLY A 20% CO-INSURANCE REQUIREMENT FOR OTHER SERVICES PROVIDED IN THE PHYSICIAN'S OFFICE NOT SUBJECT TO THE DEDUCTIBLE UNDER THE STATE AND SCHOOL EMPLOYEES HEALTH INSURANCE PLAN; TO ESTABLISH THE MISSISSIPPI ACCESS TO CARE (MAC) OVERSIGHT COMMITTEE TO COORDINATE THE IMPLEMENTATION, FUNDING AND ANY NEEDED REVISIONS OF THE MAC PLAN FOR THE PROVISION OF SERVICES TO PERSONS WITH DISABILITIES IN THE STATE OF MISSISSIPPI; TO DIRECT THE DEPARTMENT OF MENTAL HEALTH, THE STATE DEPARTMENT OF REHABILITATION SERVICES, THE DEPARTMENT OF HUMAN SERVICES, THE STATE DEPARTMENT OF EDUCATION, THE DIVISION OF MEDICAID AND THE MISSISSIPPI DEVELOPMENTAL DISABILITIES COUNCIL TO PERFORM CERTAIN FUNCTIONS IN IMPLEMENTING THE MAC PLAN; TO AMEND SECTION 41-79-5, MISSISSIPPI CODE OF 1972, TO CONFORM FUNDING REFERENCES IN THE SCHOOL NURSE INTERVENTION PROGRAM; TO AMEND SECTION 41-7-191, MISSISSIPPI CODE OF 1972, TO AUTHORIZE A HEALTH CARE CERTIFICATE OF NEED TO A CERTAIN HOSPITAL TO PROVIDE COMPREHENSIVE MEDICAL REHABILITATION SERVICES IN CERTAIN COUNTIES; TO AMEND SECTIONS 43-13-407 AND 43-13-405, MISSISSIPPI CODE OF 1972, TO DIRECT THE STATE TREASURER TO TRANSFER $100 MILLION OF THE 2002 TOBACCO SETTLEMENT INSTALLMENT PAYMENT, AND ANNUALLY THEREAFTER, INTO THE HEALTH CARE EXPENDABLE FUND TO BE Appropriated to the Division of Medicaid for Federal Waiver Programs Pursuant to the Mississippians' Access to Healthcare (MATH) Act; and for Related Purposes.

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

SECTION 1. This act shall be known and may be cited as the "Mississippians' Access To Healthcare (MATH) Act of 2002."
SECTION 2. Section 43-13-115, Mississippi Code of 1972, is amended as follows:

43-13-115. Recipients of medical assistance shall be the following persons only:

(1) Who are qualified for public assistance grants under provisions of Title IV-A and E of the federal Social Security Act, as amended, as determined by the State Department of Human Services, including those statutorily deemed to be IV-A and low-income families and children under Section 1931 of the Social Security Act as determined by the State Department of Human Services and certified to the Division of Medicaid, but not optional groups except as specifically covered in this section.

For the purposes of this paragraph (1) and paragraphs (8), (17) and (18) of this section, any reference to Title IV-A or to Part A of Title IV of the federal Social Security Act, as amended, or the state plan under Title IV-A or Part A of Title IV, shall be considered as a reference to Title IV-A of the federal Social Security Act, as amended, and the state plan under Title IV-A, including the income and resource standards and methodologies under Title IV-A and the state plan, as they existed on July 16, 1996.

(2) Those qualified for Supplemental Security Income (SSI) benefits under Title XVI of the federal Social Security Act, as amended. The eligibility of individuals covered in this paragraph shall be determined by the Social Security Administration and certified to the Division of Medicaid.

(3) [Deleted]

(4) [Deleted]

(5) A child born on or after October 1, 1984, to a woman eligible for and receiving medical assistance under the state plan on the date of the child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such
birth and will remain eligible for such assistance for a period of one (1) year so long as the child is a member of the woman's household and the woman remains eligible for such assistance or would be eligible for assistance if pregnant. The eligibility of individuals covered in this paragraph shall be determined by the State Department of Human Services and certified to the Division of Medicaid.

(6) Children certified by the State Department of Human Services to the Division of Medicaid of whom the state and county human services agency has custody and financial responsibility, and children who are in adoptions subsidized in full or part by the Department of Human Services, including special needs children in non-Title IV-E adoption assistance, who are approvable under Title XIX of the Medicaid program.

(7) (a) Persons certified by the Division of Medicaid who are patients in a medical facility (nursing home, hospital, tuberculosis sanatorium or institution for treatment of mental diseases), and who, except for the fact that they are patients in such medical facility, would qualify for grants under Title IV, supplementary security income benefits under Title XVI or state supplements, and those aged, blind and disabled persons who would not be eligible for supplemental security income benefits under Title XVI or state supplements if they were not institutionalized in a medical facility but whose income is below the maximum standard set by the Division of Medicaid, which standard shall not exceed that prescribed by federal regulation;

(b) Individuals who have elected to receive hospice care benefits and who are eligible using the same criteria and special income limits as those in institutions as described in subparagraph (a) of this paragraph (7).

(8) Children under eighteen (18) years of age and pregnant women (including those in intact families) who meet the AFDC financial standards of the state plan approved under Title
IV-A of the federal Social Security Act, as amended. The eligibility of children covered under this paragraph shall be determined by the State Department of Human Services and certified to the Division of Medicaid.

(9) Individuals who are:

(a) Children born after September 30, 1983, who have not attained the age of nineteen (19), with family income that does not exceed one hundred percent (100%) of the nonfarm official poverty line;

(b) Pregnant women, infants and children who have not attained the age of six (6), with family income that does not exceed one hundred thirty-three percent (133%) of the federal poverty level; and

(c) Pregnant women and infants who have not attained the age of one (1), with family income that does not exceed one hundred eighty-five percent (185%) of the federal poverty level.

The eligibility of individuals covered in (a), (b) and (c) of this paragraph shall be determined by the Department of Human Services.

(10) Certain disabled children age eighteen (18) or under who are living at home, who would be eligible, if in a medical institution, for SSI or a state supplemental payment under Title XVI of the federal Social Security Act, as amended, and therefore for Medicaid under the plan, and for whom the state has made a determination as required under Section 1902(e)(3)(b) of the federal Social Security Act, as amended. The eligibility of individuals under this paragraph shall be determined by the Division of Medicaid.

(11) Individuals who are sixty-five (65) years of age or older or are disabled as determined under Section 1614(a)(3) of the federal Social Security Act, as amended, and whose income does not exceed one hundred thirty-five percent (135%) of the nonfarm official poverty line;
official poverty line as defined by the Office of Management and Budget and revised annually, and whose resources do not exceed those established by the Division of Medicaid.

The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid, and such individuals determined eligible shall receive the same Medicaid services as other categorical eligible individuals.

(12) Individuals who are qualified Medicare beneficiaries (QMB) entitled to Part A Medicare as defined under Section 301, Public Law 100-360, known as the Medicare Catastrophic Coverage Act of 1988, and whose income does not exceed one hundred percent (100%) of the nonfarm official poverty line as defined by the Office of Management and Budget and revised annually.

The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid, and such individuals determined eligible shall receive Medicare cost-sharing expenses only as more fully defined by the Medicare Catastrophic Coverage Act of 1988 and the Balanced Budget Act of 1997.

(13) (a) Individuals who are entitled to Medicare Part A as defined in Section 4501 of the Omnibus Budget Reconciliation Act of 1990, and whose income does not exceed one hundred twenty percent (120%) of the nonfarm official poverty line as defined by the Office of Management and Budget and revised annually.

Eligibility for Medicaid benefits is limited to full payment of Medicare Part B premiums.

(b) Individuals entitled to Part A of Medicare, with income above one hundred twenty percent (120%), but less than one hundred thirty-five percent (135%) of the federal poverty level, and not otherwise eligible for Medicaid. Eligibility for Medicaid benefits is limited to full payment of Medicare Part B premiums. The number of eligible individuals is limited by the
availability of the federal capped allocation at one hundred percent (100%) of federal matching funds, as more fully defined in the Balanced Budget Act of 1997.

(c) Individuals entitled to Part A of Medicare, with income of at least one hundred thirty-five percent (135%), but not exceeding one hundred seventy-five percent (175%) of the federal poverty level, and not otherwise eligible for Medicaid. Eligibility for Medicaid benefits is limited to partial payment of Medicare Part B premiums. The number of eligible individuals is limited by the availability of the federal capped allocation of one hundred percent (100%) federal matching funds, as more fully defined in the Balanced Budget Act of 1997.

The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid.

(14) [Deleted]

(15) Disabled workers who are eligible to enroll in Part A Medicare as required by Public Law 101-239, known as the Omnibus Budget Reconciliation Act of 1989, and whose income does not exceed two hundred percent (200%) of the federal poverty level as determined in accordance with the Supplemental Security Income (SSI) program. The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid and such individuals shall be entitled to buy-in coverage of Medicare Part A premiums only under the provisions of this paragraph (15).

(16) In accordance with the terms and conditions of approved Title XIX waiver from the United States Department of Health and Human Services, persons provided home- and community-based services who are physically disabled and certified by the Division of Medicaid as eligible due to applying the income and deeming requirements as if they were institutionalized.

(17) In accordance with the terms of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193), persons who become ineligible for
assistance under Title IV-A of the federal Social Security Act, as amended, because of increased income from or hours of employment of the caretaker relative or because of the expiration of the applicable earned income disregards, who were eligible for Medicaid for at least three (3) of the six (6) months preceding the month in which such ineligibility begins, shall be eligible for Medicaid assistance for up to twenty-four (24) months; however, Medicaid assistance for more than twelve (12) months may be provided only if a federal waiver is obtained to provide such assistance for more than twelve (12) months and federal and state funds are available to provide such assistance.

(18) Persons who become ineligible for assistance under Title IV-A of the federal Social Security Act, as amended, as a result, in whole or in part, of the collection or increased collection of child or spousal support under Title IV-D of the federal Social Security Act, as amended, who were eligible for Medicaid for at least three (3) of the six (6) months immediately preceding the month in which such ineligibility begins, shall be eligible for Medicaid for an additional four (4) months beginning with the month in which such ineligibility begins.

(19) Disabled workers, whose incomes are above the Medicaid eligibility limits, but below two hundred fifty percent (250%) of the federal poverty level, shall be allowed to purchase Medicaid coverage on a sliding fee scale developed by the Division of Medicaid.

(20) Medicaid eligible children under age eighteen (18) shall remain eligible for Medicaid benefits until the end of a period of twelve (12) months following an eligibility determination, or until such time that the individual exceeds age eighteen (18).

(21) Women of childbearing age whose family income does not exceed one hundred eighty-five percent (185%) of the federal poverty level. The eligibility of individuals covered under this
paragraph (21) shall be determined by the Division of Medicaid, and those individuals determined eligible shall only receive family planning services covered under Section 43-13-117(13) and not any other services covered under Medicaid. However, any individual eligible under this paragraph (21) who is also eligible under any other provision of this section shall receive the benefits to which he or she is entitled under that other provision, in addition to family planning services covered under Section 43-13-117(13).

The Division of Medicaid shall apply to the United States Secretary of Health and Human Services for a federal waiver of the applicable provisions of Title XIX of the federal Social Security Act, as amended, and any other applicable provisions of federal law as necessary to allow for the implementation of this paragraph (21). The provisions of this paragraph (21) shall be implemented from and after the date that the Division of Medicaid receives the federal waiver.

(22) Persons who are workers with a potentially severe disability, as determined by the division, shall be allowed to purchase Medicaid coverage. The term "worker with a potentially severe disability" means a person who is at least sixteen (16) years of age but under sixty-five (65) years of age, who has a physical or mental impairment that is reasonably expected to cause the person to become blind or disabled as defined under Section 1614(a) of the federal Social Security Act, as amended, if the person does not receive items and services provided under Medicaid.

The eligibility of persons under this paragraph (22) shall be conducted as a demonstration project that is consistent with Section 204 of the Ticket to Work and Work Incentives Improvement Act of 1999, Public Law 106-170, for a certain number of persons as specified by the division. The eligibility of individuals
covered under this paragraph (22) shall be determined by the Division of Medicaid.

The Division of Medicaid shall apply to the United States Secretary of Health and Human Services for a federal waiver of the applicable provisions of Title XIX of the federal Social Security Act, as amended, and any other applicable provisions of federal law as necessary to allow for the implementation of this paragraph (22). The provisions of this paragraph (22) shall be implemented from and after the date that the Division of Medicaid receives the federal waiver.

(23) Children certified by the Mississippi Department of Human Services for whom the state and county human services agency has custody and financial responsibility who are in foster care on their eighteenth birthday as reported by the Mississippi Department of Human Services shall be certified Medicaid eligible by the Division of Medicaid until their twenty-first birthday.

(24) Individuals who have not attained age sixty-five (65), are not otherwise covered by creditable coverage as defined in the Public Health Services Act, and have been screened for breast and cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act in accordance with the requirements of that act and who need treatment for breast or cervical cancer. Eligibility of individuals under this paragraph (24) shall be determined by the Division of Medicaid.

(25) Individuals who would be eligible for services in a nursing home but who live in a noninstitutional setting, whose income does not exceed the amount prescribed by federal regulation for nursing home care, and who regularly expend more than fifty percent (50%) of their monthly income on prescription drugs and over-the-counter drugs.
The eligibility of individuals covered under this paragraph (25) shall be determined by the Division of Medicaid. The individuals determined eligible shall be eligible only for prescription drugs and over-the-counter drugs covered under Section 43-13-117(9) and not for any other services covered under Section 43-13-117.

The Division of Medicaid shall apply to the United States Secretary of Health and Human Services for a federal waiver of the applicable provisions of Title XIX of the federal Social Security Act, as amended, and any other applicable provisions of federal law as necessary to allow for the implementation of this paragraph (25). The provisions of this paragraph (25) shall be implemented from and after the date that the Division of Medicaid receives the federal waiver.

(26) With respect to the Medicaid Rx Senior Eligibility Waiver Program in this paragraph (26):

(a) "Qualified Medicare Beneficiaries" means Medicare beneficiaries with incomes equal to or below one hundred percent (100%) of the federal poverty level who are eligible for Medicaid assistance for the Part A and Part B Medicare premiums and for Medicare deductibles and co-insurance requirements as set forth in Section 1905(p)(1) of Title XIX of the Social Security Act.

(b) "Specified Low-income Medicare Beneficiaries" means Medicare beneficiaries who have incomes greater than one hundred percent (100%) of the federal poverty level and less than two hundred percent (200%) of the federal poverty level and meet the requirements set forth in Section 1902(a)(E)(iii) of Title XIX of the Social Security Act.

Individuals eligible for the Medicaid Rx Senior Eligibility Waiver Program shall be entitled to the Medicaid prescription drug coverage as provided to Medicaid recipients as set forth in Title XIX of the Social Security Act. To be eligible for the program,
an individual shall meet the following requirements: (a) be a United States citizen or a lawfully admitted alien; (b) be a resident of the State of Mississippi; (c) be at least sixty-five (65) years of age; (d) meet the definition of a Qualified Medicare Beneficiary or a Specified Low-income Medicare Beneficiary as set forth in this paragraph (26); and (e) be ineligible for and/or not receiving a prescription drug benefit through a Medicare supplemental policy or any other third party payer prescription benefit. The eligibility of individuals covered under this paragraph (26) shall be determined by the Division of Medicaid. Prescription drug coverage provided to eligible beneficiaries under this paragraph (26) shall be phased-in statewide as funds become available for this purpose.

The Division of Medicaid shall apply to the United States Secretary of Health and Human Services for a federal 1115 waiver of the applicable provisions of Title XIX of the federal Social Security Act, as amended, and any other applicable provisions of federal law as necessary to allow for the implementation of this paragraph (26). The provisions of this paragraph (26) shall be implemented from and after the date that the Division of Medicaid receives the federal waiver.

(27) Persons who are workers with a potentially severe disability, as determined by the division, shall be eligible to receive diabetes case management services and Medicaid benefits. The term "worker with a potentially severe disability" means a person who is at least sixteen (16) years of age but under sixty-five (65) years of age, who has a physical or mental impairment that is reasonably expected to cause the person to become blind or disabled as defined under Section 1614(a) of the federal Social Security Act, as amended, if the person does not receive diabetes case management services and other services provided under Medicaid, the intention being to serve all uninsured or under-insured working population in Mississippi.
identified on the 2000 federal decennial census. Eligible
individuals will receive regular Medicaid benefits on a
fee-for-service basis. In addition to regular Medicaid services,
the eligible individual will receive targeted diabetes case
management services, including (a) assessment of the eligible
individual to determine service needs; (b) development of a
specific care plan; (c) referral and related activities to help
the individual obtain needed services; and (d) monitoring and
follow-up. The eligibility of individuals covered under this
paragraph (27) shall be determined by the Division of Medicaid.
Services provided under this paragraph (27) shall be phased-in
statewide as funds become available for this purpose.

The Division of Medicaid shall apply to the United States
Secretary of Health and Human Services for a federal 1115 waiver
of the applicable provisions of Title XIX of the federal Social
Security Act, as amended, and any other applicable provisions of
federal law as necessary to allow for the implementation of this
paragraph (27). The provisions of this paragraph (27) shall be
implemented from and after the date that the Division of Medicaid
receives the federal waiver.

(28) Persons who are workers with a potentially severe disability, as determined by the division, shall be
eligible to receive cardiovascular disease case management and
Medicaid benefits. The term "worker with a potentially severe
disability" means a person who is at least sixteen (16) years of
age but under sixty-five (65) years of age, who has a physical or
mental impairment that is reasonably expected to cause the person
to become blind or disabled as defined under Section 1614(a) of
the federal Social Security Act, as amended, if the person does
not receive cardiovascular disease case management services and
other services provided under Medicaid, the intention being to
serve all uninsured or under-insured working population in
Mississippi as identified in the 2000 federal decennial census.
The eligibility of individuals covered under this paragraph (28) shall be determined by the Division of Medicaid. Eligible individuals will receive regular Medicaid benefits on a fee-for-service basis. In addition to the regular Medicaid services, the eligible individual will receive targeted cardiovascular disease case management services, including (a) assessment of the eligible individual to determine service needs; (b) development of a specific care plan; (c) referral and related activities to help the individual obtain needed services; and (d) monitoring and follow-up. Services provided under this paragraph (28) shall be phased-in statewide as funds become available for this purpose.

The Division of Medicaid shall apply to the United States Secretary of Health and Human Services for a federal 1115 waiver of the applicable provisions of Title XIX of the federal Social Security Act, as amended, and any other applicable provisions of federal law as necessary to allow for the implementation of this paragraph (28). The provisions of this paragraph (28) shall be implemented from and after the date that the Division of Medicaid receives the federal waiver.

(29) Individuals who are (a) forty (40) years of age or over but have not attained age fifty (50), or (b) under forty (40) years of age and are at high risk of breast cancer, or (c) have evidence of breast mass, and are not otherwise covered by creditable coverage as defined in the Public Health Services Act, and have not been screened for breast and cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under the Public Health Service Act, and who need screening for breast or cervical cancer.

The eligibility of individuals covered under this paragraph (29) shall be determined by the Division of Medicaid. Services under this paragraph (29) will include a visit to a physician for a Pap test, a clinical breast examination, laboratory interpretation and a mammography screening. Services provided under this paragraph
(29) shall be phased-in statewide as funds become available for this purpose.

The Division of Medicaid shall apply to the United States Secretary of Health and Human Services for a federal 1115 waiver of the applicable provisions of Title XIX of the federal Social Security Act, as amended, and any other applicable provisions of federal law as necessary to allow for the implementation of this paragraph (29). The provisions of this paragraph (29) shall be implemented from and after the date that the Division of Medicaid receives the federal waiver.

SECTION 3. Section 43-13-117, Mississippi Code of 1972, is amended as follows:

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

(1) Inpatient hospital services.

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

(b) From and after July 1, 1994, the Executive Director of the Division of Medicaid shall amend the Mississippi Title XIX Inpatient Hospital Reimbursement Plan to remove the occupancy rate penalty from the calculation of the Medicaid Capital Cost Component utilized to determine total hospital costs allocated to the Medicaid program.
(c) Hospitals will receive an additional payment for the implantable programmable baclofen drug pump used to treat spasticity which is implanted on an inpatient basis. The payment pursuant to written invoice will be in addition to the facility's per diem reimbursement and will represent a reduction of costs on the facility's annual cost report, and shall not exceed Ten Thousand Dollars ($10,000.00) per year per recipient. This paragraph (c) shall stand repealed on July 1, 2005.

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

(3) Laboratory and x-ray services.

(4) Nursing facility services.

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

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

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

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

(e) The division shall develop and implement, not later than January 1, 2001, a case-mix payment add-on determined by time studies and other valid statistical data which will reimburse a nursing facility for the additional cost of caring for a resident who has a diagnosis of Alzheimer's or other related dementia and exhibits symptoms that require special care. Any such case-mix add-on payment shall be supported by a determination of additional cost. The division shall also develop and implement as part of the fair rental reimbursement system for nursing facility beds, an Alzheimer's resident bed depreciation enhanced reimbursement system which will provide an incentive to encourage nursing facilities to convert or construct beds for residents with Alzheimer's or other related dementia.

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

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

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

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

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

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

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

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

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

On July 1, 1993, all fees for periodic screening and diagnostic services under this paragraph (5) shall be increased by
twenty-five percent (25%) of the reimbursement rate in effect on June 30, 1993.

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

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

(b) Repealed.

(8) Emergency medical transportation services. On January 1, 1994, emergency medical transportation services shall be reimbursed at seventy percent (70%) of the rate established under Medicare (Title XVIII of the Social Security Act, as amended). "Emergency medical transportation services" shall mean, but shall not be limited to, the following services by a properly permitted ambulance operated by a properly licensed provider in accordance with the Emergency Medical Services Act of 1974 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids, (vi) disposable supplies, (vii) similar services.
Legend and other drugs as may be determined by the division. The division may implement a program of prior approval for drugs to the extent permitted by law. Payment by the division for covered multiple source drugs shall be limited to the lower of the upper limits established and published by the Health Care Financing Administration (HCFA) plus a dispensing fee of Four Dollars and Ninety-one Cents ($4.91), or the estimated acquisition cost (EAC) as determined by the division plus a dispensing fee of Four Dollars and Ninety-one Cents ($4.91), or the providers' usual and customary charge to the general public. The division shall allow ten (10) prescriptions per month for noninstitutionalized Medicaid recipients.

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

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

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

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

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

(11) Eyeglasses necessitated by reason of eye surgery,
and as prescribed by a physician skilled in diseases of the eye or
an optometrist, whichever the patient may select, or one (1) pair
every three (3) years as prescribed by a physician or an
optometrist, whichever the patient may select.

(12) Intermediate care facility services.

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

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

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

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

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

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

(18) (a) Notwithstanding any other provision of this section to the contrary, the division shall make additional reimbursement to hospitals which serve a disproportionate share of low-income patients and which meet the federal requirements for such payments as provided in Section 1923 of the federal Social Security Act and any applicable regulations. However, from and after January 1, 2000, no public hospital shall participate in the Medicaid disproportionate share program unless the public hospital participates in an intergovernmental transfer program as provided in Section 1903 of the federal Social Security Act and any applicable regulations. Administration and support for participating hospitals shall be provided by the Mississippi Hospital Association.

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

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

(d) The Division of Medicaid shall reimburse Critical Access Hospitals at the Medicare reimbursement rate for eligible inpatient and outpatient services.

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

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

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

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

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

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

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

(24) Managed care services in a program to be developed by the division by a public or private provider. If managed care services are provided by the division to Medicaid recipients, and those managed care services are operated, managed and controlled by and under the authority of the division, the division shall be responsible for educating the Medicaid recipients who are participants in the managed care program regarding the manner in which the participants should seek health care under the program.

Notwithstanding any other provision in this article to the contrary, the division shall establish rates of reimbursement to providers rendering care and services authorized under this paragraph (24), and may revise such rates of reimbursement without amendment to this section by the Legislature for the purpose of achieving effective and accessible health services, and for responsible containment of costs.

(25) Birthing center services.

(26) Hospice care. As used in this paragraph, the term "hospice care" means a coordinated program of active professional medical attention within the home and outpatient and inpatient care which treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses which are experienced during the final stages of illness and during dying and bereavement and meets the Medicare requirements for participation as a hospice as provided in federal regulations.
(27) Group health plan premiums and cost sharing if it is cost effective as defined by the Secretary of Health and Human Services.

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

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

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

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

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

(33) Podiatrist services.

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

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

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

(37) [Deleted]

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

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

(40) [Deleted]

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

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

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

(44) Nursing facility services for the severely disabled.

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

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

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

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

(47) The division shall make application to the Secretary of Health and Human Services for a federal 1115 waiver of the applicable provisions of Title XIX of the federal Social Security Act, as amended, and any other applicable provisions of federal law as necessary to develop and provide school nurse services authorized under Section 41-79-5, Mississippi Code of 1972, for any compulsory-school-age child attending a public school in Mississippi. Any state agency which on July 1, 2002, is providing funds for a school nurse intervention program, is hereby directed to deposit any such state funds with the Division of Medicaid to establish a pool of funds which shall be available for increasing the present funding levels of school nurses by matching Medicaid funds with federal funds. The division shall provide school nurse services to school districts based on a school nurse to student attendance population ratio of 1/750. School nurse services provided under this paragraph (47) shall be phased-in statewide as funds become available for this purpose. The division may implement and provide school nurse services under this waivered program only if funds for these services are
specifically appropriated for this purpose by the Legislature or if funds are voluntarily provided by the affected agencies.

(48) The division shall provide targeted case management services for beneficiaries who have diagnosis of diabetes or cardiovascular disease as determined by the division.

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

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

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

SECTION 4. Section 25-15-9, Mississippi Code of 1972, is amended as follows:

25-15-9. (1) (a) The board shall design a plan of health insurance for state employees which provides benefits for semiprivate rooms in addition to other incidental coverages which the board deems necessary. The amount of the coverages shall be in such reasonable amount as may be determined by the board to be adequate, after due consideration of current health costs in Mississippi. The plan shall also include major medical benefits in such amounts as the board shall determine. The board is also authorized to accept bids for such alternate coverage and optional benefits as the board shall deem proper. Any contract for alternative coverage and optional benefits shall be awarded by the
board after it has carefully studied and evaluated the bids and selected the best and most cost-effective bid. The board may reject all such bids; however, the board shall notify all bidders of the rejection and shall actively solicit new bids if all bids are rejected. The board may employ or contract for such consulting or actuarial services as may be necessary to formulate the plan, and to assist the board in the preparation of specifications and in the process of advertising for the bids for the plan. Such contracts shall be solicited and entered into in accordance with Section 25-15-5. The board shall keep a record of all persons, agents and corporations who contract with or assist the board in preparing and developing the plan. The board in a timely manner shall provide copies of this record to the members of the advisory council created in this section and those legislators, or their designees, who may attend meetings of the advisory council. The board shall provide copies of this record in the solicitation of bids for the administration or servicing of the self-insured program. Each person, agent or corporation which, during the previous fiscal year, has assisted in the development of the plan or employed or compensated any person who assisted in the development of the plan, and which bids on the administration or servicing of the plan, shall submit to the board a statement accompanying the bid explaining in detail its participation with the development of the plan. This statement shall include the amount of compensation paid by the bidder to any such employee during the previous fiscal year. The board shall make all such information available to the members of the advisory council and those legislators, or their designees, who may attend meetings of the advisory council before any action is taken by the board on the bids submitted. The failure of any bidder to fully and accurately comply with this paragraph shall result in the rejection of any bid submitted by that bidder or the cancellation of any contract executed when the failure is discovered after the...
acceptance of that bid. The board is authorized to promulgate rules and regulations to implement the provisions of this subsection.

The board shall develop plans for the insurance plan authorized by this section in accordance with the provisions of Section 25-15-5.

Any corporation, association, company or individual that contracts with the board for the third-party claims administration of the self-insured plan shall prepare and keep on file an explanation of benefits for each claim processed. The explanation of benefits shall contain such information relative to each processed claim which the board deems necessary, and, at a minimum, each explanation shall provide the claimant's name, claim number, provider number, provider name, service dates, type of services, amount of charges, amount allowed to the claimant and reason codes. The information contained in the explanation of benefits shall be available for inspection upon request by the board. The board shall have access to all claims information utilized in the issuance of payments to employees and providers.

(b) There is created an advisory council to advise the board in the formulation of the State and School Employees Health Insurance Plan. The council shall be composed of the State Insurance Commissioner or his designee, an employee-representative of the institutions of higher learning appointed by the board of trustees thereof, an employee-representative of the Department of Transportation appointed by the director thereof, an employee-representative of the State Tax Commission appointed by the Commissioner of Revenue, an employee-representative of the Mississippi Department of Health appointed by the State Health Officer, an employee-representative of the Mississippi Department of Corrections appointed by the Commissioner of Corrections, and an employee-representative of the Department of Human Services appointed by the Executive Director of Human Services, two (2)
certificated public school administrators appointed by the State Board of Education, two (2) certificated classroom teachers appointed by the State Board of Education, a noncertificated school employee appointed by the State Board of Education and a community/junior college employee appointed by the State Board for Community and Junior Colleges.

The Lieutenant Governor may designate the Secretary of the Senate, the Chairman of the Senate Appropriations Committee, the Chairman of the Senate Education Committee and the Chairman of the Senate Insurance Committee, and the Speaker of the House of Representatives may designate the Clerk of the House, the Chairman of the House Appropriations Committee, the Chairman of the House Education Committee and the Chairman of the House Insurance Committee, to attend any meeting of the State and School Employees Insurance Advisory Council. The appointing authorities may designate an alternate member from their respective houses to serve when the regular designee is unable to attend such meetings of the council. Such designees shall have no jurisdiction or vote on any matter within the jurisdiction of the council. For attending meetings of the council, such legislators shall receive per diem and expenses which shall be paid from the contingent expense funds of their respective houses in the same amounts as provided for committee meetings when the Legislature is not in session; however, no per diem and expenses for attending meetings of the council will be paid while the Legislature is in session. No per diem and expenses will be paid except for attending meetings of the council without prior approval of the proper committee in their respective houses.

(c) No change in the terms of the State and School Employees Health Insurance Plan may be made effective unless the board, or its designee, has provided notice to the State and School Employees Health Insurance Advisory Council and has called a meeting of the council at least fifteen (15) days before the
effective date of such change. In the event that the State and
School Employees Health Insurance Advisory Council does not meet
to advise the board on the proposed changes, the changes to the
plan shall become effective at such time as the board has informed
the council that the changes shall become effective.

(d) Medical benefits for retired employees and
dependents under age sixty-five (65) years and not eligible for
Medicare benefits. The same health insurance coverage as for all
other active employees and their dependents shall be available to
retired employees and all dependents under age sixty-five (65)
years who are not eligible for Medicare benefits, the level of
benefits to be the same level as for all other active
participants. This section will apply to those employees who
retire due to one hundred percent (100%) medical disability as
well as those employees electing early retirement.

(e) Medical benefits for retired employees and
dependents over age sixty-five (65) years or otherwise eligible
for Medicare benefits. The health insurance coverage available to
retired employees over age sixty-five (65) years or otherwise
eligible for Medicare benefits, and all dependents over age
sixty-five (65) years or otherwise eligible for Medicare benefits,
shall be the major medical coverage with the lifetime maximum of
One Million Dollars ($1,000,000.00). Benefits shall be reduced by
Medicare benefits as though such Medicare benefits were the base
plan.

All covered individuals shall be assumed to have full
Medicare coverage, Parts A and B; and any Medicare payments under
both Parts A and B shall be computed to reduce benefits payable
under this plan.

(2) Nonduplication of benefits—reduction of benefits by
Title XIX benefits: When benefits would be payable under more
than one (1) group plan, benefits under those plans will be
coordinated to the extent that the total benefits under all plans will not exceed the total expenses incurred.

Benefits for hospital or surgical or medical benefits shall be reduced by any similar benefits payable in accordance with Title XIX of the Social Security Act or under any amendments thereto, or any implementing legislation.

Benefits for hospital or surgical or medical benefits shall be reduced by any similar benefits payable by workers' compensation.

(3) (a) Schedule of life insurance benefits--group term: The amount of term life insurance for each active employee of a department, agency or institution of the state government shall not be in excess of One Hundred Thousand Dollars ($100,000.00), or twice the amount of the employee's annual wage to the next highest One Thousand Dollars ($1,000.00), whichever may be less, but in no case less than Thirty Thousand Dollars ($30,000.00), with a like amount for accidental death and dismemberment on a twenty-four-hour basis. The plan will further contain a premium waiver provision if a covered employee becomes totally and permanently disabled prior to age sixty-five (65) years.

Employees retiring after June 30, 1999, shall be eligible to continue life insurance coverage in an amount of Five Thousand Dollars ($5,000.00), Ten Thousand Dollars ($10,000.00) or Twenty Thousand Dollars ($20,000.00) into retirement.

(b) Effective October 1, 1999, schedule of life insurance benefits--group term: The amount of term life insurance for each active employee of any school district, community/junior college, public library or university-based program authorized under Section 37-23-31 for deaf, aphasic and emotionally disturbed children or any regular nonstudent bus driver shall not be in excess of One Hundred Thousand Dollars ($100,000.00), or twice the amount of the employee's annual wage to the next highest One Thousand Dollars ($1,000.00), whichever may be less, but in no
case less than Thirty Thousand Dollars ($30,000.00), with a like amount for accidental death and dismemberment on a twenty-four-hour basis. The plan will further contain a premium waiver provision if a covered employee of any school district, community/junior college, public library or university-based program authorized under Section 37-23-31 for deaf, aphasic and emotionally disturbed children or any regular nonstudent bus driver becomes totally and permanently disabled prior to age sixty-five (65) years. Employees of any school district, community/junior college, public library or university-based program authorized under Section 37-23-31 for deaf, aphasic and emotionally disturbed children or any regular nonstudent bus driver retiring after September 30, 1999, shall be eligible to continue life insurance coverage in an amount of Five Thousand Dollars ($5,000.00), Ten Thousand Dollars ($10,000.00) or Twenty Thousand Dollars ($20,000.00) into retirement.

(4) Any eligible employee who on March 1, 1971, was participating in a group life insurance program which has provisions different from those included herein and for which the State of Mississippi was paying a part of the premium may, at his discretion, continue to participate in such plan. Such employee shall pay in full all additional costs, if any, above the minimum program established by this article. Under no circumstances shall any individual who begins employment with the state after March 1, 1971, be eligible for the provisions of this paragraph.

(5) The board may offer medical savings accounts as defined in Section 71-9-3 as a plan option.

(6) Any premium differentials, differences in coverages, discounts determined by risk or by any other factors shall be uniformly applied to all active employees participating in the insurance plan. It is the intent of the Legislature that the state contribution to the plan be the same for each employee throughout the state.
(7) On October 1, 1999, any school district, community/junior college district or public library may elect to remain with an existing policy or policies of group life insurance with an insurance company approved by the State and School Employees Health Insurance Management Board, in lieu of participation in the State and School Life Insurance Plan. The state's contribution of up to fifty percent (50%) of the active employee's premium under the State and School Life Insurance Plan may be applied toward the cost of coverage for full-time employees participating in the approved life insurance company group plan. For purposes of this subsection (7), "life insurance company group plan" means a plan administered or sold by a private insurance company. After October 1, 1999, the board may assess charges in addition to the existing State and School Life Insurance Plan rates to such employees as a condition of enrollment in the State and School Life Insurance Plan. In order for any life insurance company group plan existing as of October 1, 1999, to be approved by the State and School Employees Health Insurance Management Board under this subsection (7), it shall meet the following criteria:

(a) The insurance company offering the group life insurance plan shall be rated "A-" or better by A.M. Best state insurance rating service and be licensed as an admitted carrier in the State of Mississippi by the Mississippi Department of Insurance.

(b) The insurance company group life insurance plan shall provide the same life insurance, accidental death and dismemberment insurance and waiver of premium benefits as provided in the State and School Life Insurance Plan.

(c) The insurance company group life insurance plan shall be fully insured, and no form of self-funding life insurance by such company shall be approved.
(d) The insurance company group life insurance plan shall have one (1) composite rate per One Thousand Dollars ($1,000.00) of coverage for active employees regardless of age and one (1) composite rate per One Thousand Dollars ($1,000.00) of coverage for all retirees regardless of age or type of retiree.

(e) The insurance company and its group life insurance plan shall comply with any administrative requirements of the State and School Employees Health Insurance Management Board. In the event any insurance company providing group life insurance benefits to employees under this subsection (7) fails to comply with any requirements specified herein or any administrative requirements of the board, the state shall discontinue providing funding for the cost of such insurance.

(8) On or after July 1, 2002, the State and School Employees Health Insurance Management Board is authorized and directed to revise the state health plan to enhance employee and dependent coverage benefits as follows: (a) eliminate the deductible amount for a network physician office visit by the employee or a dependent; (b) institute a co-payment requirement for the physician visit of Fifteen Dollars ($15.00) for a primary care physician visit and Twenty-five Dollars ($25.00) for a specialist visit; (c) apply a twenty percent (20%) co-insurance requirement for other services provided in the physician's office or clinic which are not subject to the deductible.

SECTION 5. (1) There is established the Mississippi Access to Care (MAC) Oversight Committee to coordinate the implementation, funding and any needed revisions of the MAC plan dated September 30, 2001, that was prepared and submitted to the Legislature as required under Sections 43-57-1 through 43-57-9.

(2) The MAC Oversight Committee shall be composed of:

(a) Six (6) members appointed by the Governor, at least five (5) of whom must be persons with disabilities;

(b) Four (4) members appointed by the Lieutenant Governor.
Governor, at least three (3) of whom must be persons with disabilities;

(c) The executive directors of the Department of Mental Health, the State Department of Rehabilitation Services, the Department of Human Services and the Division of Medicaid, or their designees;

(d) A representative of the Governor's office;

(e) The Chairs and Vice Chairs of the Public Health and Welfare Committee and the Appropriations Committee of the House of Representatives, as nonvoting members; and

(f) The Chairs and Vice Chairs of the Public Health and Welfare Committee and the Appropriations Committee of the Senate, as nonvoting members.

(3) (a) Of the Governor's appointments, one (1) member shall be appointed from each congressional district as constituted on July 1, 2002, and two (2) members shall be appointed from the state at large. The initial appointments of the Governor shall be made as follows: one (1) member shall be appointed for a term ending on June 30, 2003, two (2) members shall be appointed for terms ending on June 30, 2004, one (1) member shall be appointed for a term ending on June 30, 2005, and two (2) members shall be appointed for terms ending on June 30, 2006. All subsequent appointments shall be for terms of four (4) years from the expiration date of the previous term. Any vacancy before the expiration of a term shall be filled by appointment of the Governor, and the person appointed to fill the vacancy shall serve for the remainder of the unexpired term.

(b) Of the Lieutenant Governor's appointments, one (1) member shall be appointed from each congressional district as constituted on July 1, 2002. The initial appointments of the Lieutenant Governor shall be made as follows: one (1) member shall be appointed for a term ending on June 30, 2003, one (1) member shall be appointed for a term ending on June 30, 2004, one...
(1) member shall be appointed for a term ending on June 30, 2005, and one (1) member shall be appointed for a term ending on June 30, 2006. All subsequent appointments shall be for terms of four (4) years from the expiration date of the previous term. Any vacancy before the expiration of a term shall be filled by appointment of the Lieutenant Governor, and the person appointed to fill the vacancy shall serve for the remainder of the unexpired term.

(3) At the first meeting of the committee, the members shall select one (1) member to serve as chair of the committee. The committee shall select a chair once every two (2) years, and any person who has previously served as chair may be reelected as chair.

(4) Eight (8) of the voting members of the committee shall constitute a quorum for the transaction of any business of the committee. The committee shall meet at least once each quarter, and may meet at other times as necessary for the purpose of conducting any business that may be required. All meetings shall be called by the chair or by a majority of the voting members of the committee, except the first meeting, which shall be called by the Governor.

(5) The appointed members and the legislative members of the committee shall receive a per diem in the amount provided under Section 25-3-69 for each day engaged in the official business of the committee. The appointed members of the committee other than the legislative members shall receive reimbursement for travel expenses incurred while engaged in official business of the committee in accordance with Section 25-3-41, and the legislative members of the committee shall receive the expense allowance provided for in Section 5-1-47. However, the legislative members of the committee shall not receive the per diem or expense allowance for any day that the committee meets while the Legislature is in session.
SECTION 6. (1) The MAC Oversight Committee is ultimately responsible for implementation of the MAC plan. The committee shall continually review and assess the three-part test for states and the three (3) risk zones for states to fulfill the state's obligation to:

(a) Divert persons from initially being placed into institutions;

(b) Review those persons already in institutions to determine how many could be and want to be served in a home- and community-based setting; and

(c) Respond to individual requests by institutionalized persons to leave the institutional setting to go to a home- and community-based setting.

(2) The duties of the MAC Oversight Committee are to:

(a) Identify, collect, and disburse data regarding the number and status of persons with disabilities and the availability and quality of community services and supports;

(b) Monitor the development and expansion of community services and the movement on the waiting list;

(c) Actively and continuously review and recommend modifications to the MAC plan;

(d) Provide persons with disabilities a process for independent review and appeal of decisions made by treating professionals;

(e) Develop the specific criteria and tools to measure the effectiveness of the MAC plan strategies, submit them to the responsible agency or agencies for concurrence, and make an annual report to the Legislature of the outcomes;

(f) Hold periodic public meetings to provide information and opportunities for input;

(g) In conjunction with the Governor's Commission on Disability, establish a single point of intake for persons with disabilities.
disabilities to provide an independent identifying, screening and referring process;

(h) Identify specific steps for the provision of a comprehensive system of support services to persons once they are identified; and

(i) Establish a baseline for the existing waiting time for each service, define what constitutes a "reasonable pace" for providing community services, and design and implement a plan to move from the current waiting time to a time that is "reasonable."

SECTION 7. (1) In implementing the MAC plan, the Department of Mental Health, the State Department of Rehabilitation Services, the Department of Human Services, the State Department of Education and the Division of Medicaid each shall:

(a) Develop and maintain an ongoing, comprehensive data collection system for identifying persons with disabilities who are receiving or are in need of services and supports from that agency;

(b) Develop and implement a comprehensive evaluation procedure ensuring that, where appropriate, each person with disabilities and/or the person's guardian will be involved in the assessment and planning process and that the assessment will be directed toward providing services in the "least restricted, most integrated setting possible" based upon professional recommendations and the choice of the person and his or her family; and

(c) Provide to the MAC Oversight Committee with reports specifying the agency's budgetary and program implementation response to the MAC plan. Each agency shall provide the reports to the committee at least twice annually, and at other times as required by the committee.

(i) The first report required by this paragraph shall be provided to the committee after the development of the agency's budget and before the beginning of the Joint Legislative
Budget Committee's hearings on agency budget requests in the fall of the year. That report shall detail the portions of the agency's budget request that would be directed toward the implementation of the MAC plan, including the number of citizens to be served and the specific services to be provided, the amount of money required to provide the services and the source of the funding.

(ii) The second report required by this paragraph shall be provided to the committee not later than thirty (30) days after the end of the regular session of the Legislature. That report shall include the same information as in the first report, except that it shall detail the portions of the agency’s proposed budget that the Legislature funded. The second report also shall include a more detailed narrative of the services that must be carried forward to the next budgetary cycle and the services that require amendment due to the funding that was made available.

SECTION 8. In implementing the MAC plan, the MAC Oversight Committee shall:

(a) Establish a consumer friendly, single point of entry referral system for persons with disabilities who need assistance identifying and/or accessing appropriate and desired services, and an evaluation/assessment procedure working in together with the referral system;

(b) Identify those persons with disabilities currently in nursing facilities, advise them of the home- and community-based alternatives available and allow them the option to choose the most integrated setting of their choice; and

(c) Act as the lead agency responsible for developing and coordinating a comprehensive housing plan for persons with all types of disabilities. The plan shall address the following components:

(i) Identification of persons with disabilities needing or wanting community-based housing;
(ii) Support services needed by persons with disabilities to live independently;

(iii) Funding assistance for housing.

(d) Act as the lead entity responsible for developing and implementing a comprehensive transportation plan for all persons with disabilities that will maximize existing resources and develop future funding requests;

(e) Establish creative transportation initiatives and demonstration projects;

(f) Develop a transportation guide for all persons with disabilities; and

(g) Perform a feasibility study in fiscal year 2004 to determine options for an interagency, consolidated transportation plan.

SECTION 9. Section 41-79-5, Mississippi Code of 1972, is amended as follows:

41-79-5. (1) There is hereby established within the State Department of Health a school nurse intervention program, available to all public school districts in the state.

(2) By the school year 1998-1999, each public school district shall have employed a school nurse, to be known as a Health Service Coordinator, pursuant to the school nurse intervention program prescribed under this section. The school nurse intervention program shall offer any of the following specific preventive services, and other additional services appropriate to each grade level and the age and maturity of the pupils:

(a) Reproductive health education and referral to prevent teen pregnancy and sexually transmitted diseases, which education shall include abstinence;

(b) Child abuse and neglect identification;
(c) Hearing and vision screening to detect problems which can lead to serious sensory losses and behavioral and academic problems;

(d) Alcohol, tobacco and drug abuse education to reduce abuse of these substances;

(e) Scoliosis screening to detect this condition so that costly and painful surgery and lifelong disability can be prevented;

(f) Coordination of services for handicapped children to ensure that these children receive appropriate medical assistance and are able to remain in public school;

(g) Nutrition education and counseling to prevent obesity and/or other eating disorders which may lead to life-threatening conditions, for example, hypertension;

(h) Early detection and treatment of head lice to prevent the spread of the parasite and to reduce absenteeism;

(i) Emergency treatment of injury and illness to include controlling bleeding, managing fractures, bruises or contusions and cardiopulmonary resuscitation (CPR);

(j) Applying appropriate theory as the basis for decision making in nursing practice;

(k) Establishing and maintaining a comprehensive school health program;

(l) Developing individualized health plans;

(m) Assessing, planning, implementing and evaluating programs and other school health activities, in collaboration with other professionals;

(n) Providing health education to assist students, families and groups to achieve optimal levels of wellness;

(o) Participating in peer review and other means of evaluation to assure quality of nursing care provided for students and assuming responsibility for continuing education and
professional development for self while contributing to the professional growth of others;

(p) Participating with other key members of the community responsible for assessing, planning, implementing and evaluating school health services and community services that include the broad continuum or promotion of primary, secondary and tertiary prevention; and

(q) Contributing to nursing and school health through innovations in theory and practice and participation in research.

(3) Public school nurses shall be specifically prohibited from providing abortion counseling to any student or referring any student to abortion counseling or abortion clinics. Any violation of this subsection shall disqualify the school district employing such public school nurse from receiving any state administered funds under this section.

(4) (Repealed)

(5) Beginning with the 1997-1998 school year, to the extent that federal or state funds are available therefor and pursuant to appropriation therefor by the Legislature, in addition to the school nurse intervention program funds administered under subsection (4), the State Department of Health shall establish and implement a Prevention of Teen Pregnancy Pilot Program to be located in the public school districts with the highest numbers of teen pregnancies. The Teen Pregnancy Pilot Program shall provide the following education services directly through public school nurses in the pilot school districts: health education sessions in local schools, where contracted for or invited to provide, which target issues including reproductive health, teen pregnancy prevention and sexually transmitted diseases, including syphilis, HIV and AIDS. When these services are provided by a school nurse, training and counseling on abstinence shall be included.

(6) In addition to the school nurse intervention program funds administered under subsection (4) and the Teen Pregnancy
Pilot Program funds administered under subsection (5), to the extent that federal or state funds are available therefor and pursuant to appropriation therefor by the Legislature, the State Department of Health shall establish and implement an Abstinence Education Pilot Program to provide abstinence education, mentoring, counseling and adult supervision to promote abstinence from sexual activity, with a focus on those groups which are most likely to bear children out of wedlock. Such abstinence education services shall be provided by the State Department of Health through its clinics, public health nurses, school nurses and through contracts with rural and community health centers in order to reach a larger number of targeted clients. For purposes of this subsection, the term "abstinence education" means an educational or motivational program which:

(a) Has as its exclusive purpose, teaching the social, psychological and health gains to be realized by abstaining from sexual activity;

(b) Teaches abstinence from sexual activity outside marriage as the expected standard for all school-age children;

(c) Teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases and other associated health problems;

(d) Teaches that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity;

(e) Teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;

(f) Teaches that bearing children out of wedlock is likely to have harmful consequences for the child, the child's parents and society;
(g) Teaches young people how to reject sexual advances and how alcohol and drug use increase vulnerability to sexual advances; and

(h) Teaches the importance of attaining self-sufficiency before engaging in sexual activity.

(7) Beginning with the 2002-2003 school year and pursuant to appropriation therefor by the Legislature, in addition to other funds allotted under the Mississippi Adequate Education Program, each school district shall be provided funds from the Division of Medicaid school nurse waiver program authorized in Section 43-13-117(47), Mississippi Code of 1972, for the purpose of employing qualified public school nurses in such school district using a school nurse to student attendance population ratio of 1/750, which in no event shall be less than one (1) school nurse per school district, for such purpose. In the event the Legislature provides less funds than the total * * * funds needed for the public school nurse intervention program, those school districts with fewer school nurses shall be the first funded for such purpose, to the extent of funds available.

(8) Prior to the 1998-1999 school year, nursing staff assigned to the program shall be employed through the local county health department and shall be subject to the supervision of the State Department of Health with input from local school officials. Local county health departments may contract with any comprehensive private primary health care facilities within their county to employ and utilize additional nursing staff. Beginning with the 1998-1999 school year, nursing staff assigned to the program shall be employed by the local school district and shall be designated as "health service coordinators," and shall be required to possess a registered nurse license (RN) as a minimum qualification.

(9) Upon each student's enrollment, the parent or guardian shall be provided with information regarding the scope of the
school nurse intervention program. The parent or guardian may provide the school administration with a written statement refusing all or any part of the nursing service. No child shall be required to undergo hearing and vision or scoliosis screening or any other physical examination or tests whose parent objects thereto on the grounds such screening, physical examination or tests are contrary to his sincerely held religious beliefs.

(10) A consent form for reproductive health education shall be sent to the parent or guardian of each student upon his enrollment. If a response from the parent or guardian is not received within seven (7) days after the consent form is sent, the school shall send a letter to the student's home notifying the parent or guardian of the consent form. If the parent or guardian fails to respond to the letter within ten (10) days after it is sent, then the school principal shall be authorized to allow the student to receive reproductive health education. Reproductive health education shall include the teaching of total abstinence from premarital sex and, wherever practicable, reproductive health education should be taught in classes divided according to gender. All materials used in the reproductive health education program shall be placed in a convenient and easily accessible location for parental inspection. School nurses shall not dispense birth control pills or contraceptive devices in the school. Dispensing of such shall be the responsibility of the State Department of Health on a referral basis only.

(11) No provision of this section shall be construed as prohibiting local school districts from accepting financial assistance of any type from the State of Mississippi or any other governmental entity, or any contribution, donation, gift, decree or bequest from any source which may be utilized for the maintenance or implementation of a school nurse intervention program in a public school system of this state.
SECTION 10. Section 41-7-191, Mississippi Code of 1972, is amended as follows:

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

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

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

(c) A change over a period of two (2) years' time, as established by the State Department of Health, in existing bed complement through the addition of more than ten (10) beds or more than ten percent (10%) of the total bed capacity of a designated licensed category or subcategory of any health care facility, whichever is less, from one physical facility or site to another; the conversion over a period of two (2) years' time, as established by the State Department of Health, of existing bed complement of more than ten (10) beds or more than ten percent (10%) of the total bed capacity of a designated licensed category or subcategory of any such health care facility, whichever is less; or the alteration, modernizing or refurbishing of any unit or department wherein such beds may be located; provided, however, that from and after July 1, 1994, no health care facility shall be authorized to add any beds or convert any beds to another category of beds without a certificate of need under the authority of subsection (1)(c) of this section unless there is a projected need for such beds in the planning district in which the facility is located, as reported in the most current State Health Plan;
(d) Offering of the following health services if those services have not been provided on a regular basis by the proposed provider of such services within the period of twelve (12) months prior to the time such services would be offered:

(i) Open heart surgery services;
(ii) Cardiac catheterization services;
(iii) Comprehensive inpatient rehabilitation services;
(iv) Licensed psychiatric services;
(v) Licensed chemical dependency services;
(vi) Radiation therapy services;
(vii) Diagnostic imaging services of an invasive nature, i.e. invasive digital angiography;
(viii) Nursing home care as defined in subparagraphs (iv), (vi) and (viii) of Section 41-7-173(h);
(ix) Home health services;
(x) Swing-bed services;
(xi) Ambulatory surgical services;
(xii) Magnetic resonance imaging services;
(xiii) Extracorporeal shock wave lithotripsy services;
(xiv) Long-term care hospital services;
(xv) Positron Emission Tomography (PET) services;

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

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

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

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

(i) Any activity described in paragraphs (a) through
(h) if undertaken by any person if that same activity would
require certificate of need approval if undertaken by a health
care facility;
(j) Any capital expenditure or deferred capital expenditure by or on behalf of a health care facility not covered by paragraphs (a) through (h);

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

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

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

(b) The department may issue certificates of need in Harrison County to provide skilled nursing home care for Alzheimer's Disease patients and other patients, not to exceed one hundred fifty (150) beds. From and after July 1, 1999, there shall be no prohibition or restrictions on participation in the Medicaid program (Section 43-13-101 et seq.) for the beds in the nursing facilities that were authorized under this paragraph (b).
(c) The department may issue a certificate of need for the addition to or expansion of any skilled nursing facility that is part of an existing continuing care retirement community located in Madison County, provided that the recipient of the certificate of need agrees in writing that the skilled nursing facility will not at any time participate in the Medicaid program (Section 43-13-101 et seq.) or admit or keep any patients in the skilled nursing facility who are participating in the Medicaid program. This written agreement by the recipient of the certificate of need shall be fully binding on any subsequent owner of the skilled nursing facility, if the ownership of the facility is transferred at any time after the issuance of the certificate of need. Agreement that the skilled nursing facility will not participate in the Medicaid program shall be a condition of the issuance of a certificate of need to any person under this paragraph (c), and if such skilled nursing facility at any time after the issuance of the certificate of need, regardless of the ownership of the facility, participates in the Medicaid program or admits or keeps any patients in the facility who are participating in the Medicaid program, the State Department of Health shall revoke the certificate of need, if it is still outstanding, and shall deny or revoke the license of the skilled nursing facility, at the time that the department determines, after a hearing complying with due process, that the facility has failed to comply with any of the conditions upon which the certificate of need was issued, as provided in this paragraph and in the written agreement by the recipient of the certificate of need. The total number of beds that may be authorized under the authority of this paragraph (c) shall not exceed sixty (60) beds.

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

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

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

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

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

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

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

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

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

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

(m) The State Department of Health may issue a certificate of need to a county-owned hospital in the Second Judicial District of Panola County for the conversion of not more than seventy-two (72) hospital beds to nursing facility beds, provided that the recipient of the certificate of need agrees in
writing that none of the beds at the nursing facility will be certified for participation in the Medicaid program (Section 43-13-101 et seq.), and that no claim will be submitted for Medicaid reimbursement in the nursing facility in any day or for any patient in the nursing facility. This written agreement by the recipient of the certificate of need shall be a condition of the issuance of the certificate of need under this paragraph, and the agreement shall be fully binding on any subsequent owner of the nursing facility if the ownership of the nursing facility is transferred at any time after the issuance of the certificate of need. After this written agreement is executed, the Division of Medicaid and the State Department of Health shall not certify any of the beds in the nursing facility for participation in the Medicaid program. If the nursing facility violates the terms of the written agreement by admitting or keeping in the nursing facility on a regular or continuing basis any patients who are participating in the Medicaid program, the State Department of Health shall revoke the license of the nursing facility, at the time that the department determines, after a hearing complying with due process, that the nursing facility has violated the condition upon which the certificate of need was issued, as provided in this paragraph and in the written agreement. If the certificate of need authorized under this paragraph is not issued within twelve (12) months after July 1, 2001, the department shall deny the application for the certificate of need and shall not issue the certificate of need at any time after the twelve-month period, unless the issuance is contested. If the certificate of need is issued and substantial construction of the nursing facility beds has not commenced within eighteen (18) months after July 1, 2001, the State Department of Health, after a hearing complying with due process, shall revoke the certificate of need if it is still outstanding, and the department shall not issue a license for the nursing facility at any time after the
eighteen-month period. Provided, however, that if the issuance of
the certificate of need is contested, the department shall require
substantial construction of the nursing facility beds within six
(6) months after final adjudication on the issuance of the
certificate of need.

(n) The department may issue a certificate of need for
the new construction, addition or conversion of skilled nursing
facility beds in Madison County, provided that the recipient of
the certificate of need agrees in writing that the skilled nursing
facility will not at any time participate in the Medicaid program
(Section 43-13-101 et seq.) or admit or keep any patients in the
skilled nursing facility who are participating in the Medicaid
program. This written agreement by the recipient of the
certificate of need shall be fully binding on any subsequent owner
of the skilled nursing facility, if the ownership of the facility
is transferred at any time after the issuance of the certificate
of need. Agreement that the skilled nursing facility will not
participate in the Medicaid program shall be a condition of the
issuance of a certificate of need to any person under this
paragraph (n), and if such skilled nursing facility at any time
after the issuance of the certificate of need, regardless of the
ownership of the facility, participates in the Medicaid program or
admits or keeps any patients in the facility who are participating
in the Medicaid program, the State Department of Health shall
revoke the certificate of need, if it is still outstanding, and
shall deny or revoke the license of the skilled nursing facility,
at the time that the department determines, after a hearing
complying with due process, that the facility has failed to comply
with any of the conditions upon which the certificate of need was
issued, as provided in this paragraph and in the written agreement
by the recipient of the certificate of need. The total number of
nursing facility beds that may be authorized by any certificate of
need issued under this paragraph (n) shall not exceed sixty (60)
beds. If the certificate of need authorized under this paragraph is not issued within twelve (12) months after July 1, 1998, the department shall deny the application for the certificate of need and shall not issue the certificate of need at any time after the twelve-month period, unless the issuance is contested. If the certificate of need is issued and substantial construction of the nursing facility beds has not commenced within eighteen (18) months after the effective date of July 1, 1998, the State Department of Health, after a hearing complying with due process, shall revoke the certificate of need if it is still outstanding, and the department shall not issue a license for the nursing facility at any time after the eighteen-month period. Provided, however, that if the issuance of the certificate of need is contested, the department shall require substantial construction of the nursing facility beds within six (6) months after final adjudication on the issuance of the certificate of need.

(o) The department may issue a certificate of need for the new construction, addition or conversion of skilled nursing facility beds in Leake County, provided that the recipient of the certificate of need agrees in writing that the skilled nursing facility will not at any time participate in the Medicaid program (Section 43-13-101 et seq.) or admit or keep any patients in the skilled nursing facility who are participating in the Medicaid program. This written agreement by the recipient of the certificate of need shall be fully binding on any subsequent owner of the skilled nursing facility, if the ownership of the facility is transferred at any time after the issuance of the certificate of need. Agreement that the skilled nursing facility will not participate in the Medicaid program shall be a condition of the issuance of a certificate of need to any person under this paragraph (o), and if such skilled nursing facility at any time after the issuance of the certificate of need, regardless of the ownership of the facility, participates in the Medicaid program or
admits or keeps any patients in the facility who are participating
in the Medicaid program, the State Department of Health shall
revoke the certificate of need, if it is still outstanding, and
shall deny or revoke the license of the skilled nursing facility,
at the time that the department determines, after a hearing
complying with due process, that the facility has failed to comply
with any of the conditions upon which the certificate of need was
issued, as provided in this paragraph and in the written agreement
by the recipient of the certificate of need. The total number of
nursing facility beds that may be authorized by any certificate of
need issued under this paragraph (o) shall not exceed sixty (60)
beds. If the certificate of need authorized under this paragraph
is not issued within twelve (12) months after July 1, 2001, the
department shall deny the application for the certificate of need
and shall not issue the certificate of need at any time after the
twelve-month period, unless the issuance is contested. If the
certificate of need is issued and substantial construction of the
nursing facility beds has not commenced within eighteen (18)
months after the effective date of July 1, 2001, the State
Department of Health, after a hearing complying with due process,
shall revoke the certificate of need if it is still outstanding,
and the department shall not issue a license for the nursing
facility at any time after the eighteen-month period. Provided,
however, that if the issuance of the certificate of need is
contested, the department shall require substantial construction
of the nursing facility beds within six (6) months after final
adjudication on the issuance of the certificate of need.

(p) The department may issue a certificate of need for
the construction of a municipally-owned nursing facility within
the Town of Belmont in Tishomingo County, not to exceed sixty (60)
beds, provided that the recipient of the certificate of need
agrees in writing that the skilled nursing facility will not at
any time participate in the Medicaid program (Section 43-13-101 et
or admit or keep any patients in the skilled nursing facility who are participating in the Medicaid program. This written agreement by the recipient of the certificate of need shall be fully binding on any subsequent owner of the skilled nursing facility, if the ownership of the facility is transferred at any time after the issuance of the certificate of need. Agreement that the skilled nursing facility will not participate in the Medicaid program shall be a condition of the issuance of a certificate of need to any person under this paragraph (p), and if such skilled nursing facility at any time after the issuance of the certificate of need, regardless of the ownership of the facility, participates in the Medicaid program or admits or keeps any patients in the facility who are participating in the Medicaid program, the State Department of Health shall revoke the certificate of need, if it is still outstanding, and shall deny or revoke the license of the skilled nursing facility, at the time that the department determines, after a hearing complying with due process, that the facility has failed to comply with any of the conditions upon which the certificate of need was issued, as provided in this paragraph and in the written agreement by the recipient of the certificate of need. The provision of Section 43-7-193(1) regarding substantial compliance of the projection of need as reported in the current State Health Plan is waived for the purposes of this paragraph. If the certificate of need authorized under this paragraph is not issued within twelve (12) months after July 1, 1998, the department shall deny the application for the certificate of need and shall not issue the certificate of need at any time after the twelve-month period, unless the issuance is contested. If the certificate of need is issued and substantial construction of the nursing facility beds has not commenced within eighteen (18) months after July 1, 1998, the State Department of Health, after a hearing complying with due process, shall revoke the certificate of need if it is still
outstanding, and the department shall not issue a license for the
nursing facility at any time after the eighteen-month period.
Provided, however, that if the issuance of the certificate of need
is contested, the department shall require substantial
construction of the nursing facility beds within six (6) months
after final adjudication on the issuance of the certificate of
need.

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

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

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

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

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

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

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

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

(ii) Not more than twenty (20) beds may be authorized by any certificate of need issued under this paragraph (r), and not more than a total of sixty (60) beds may be authorized in any Long-Term Care Planning District by all certificates of need issued under this paragraph (r). However, the total number of beds that may be authorized by all certificates of need issued under this paragraph (r) during any fiscal year shall not exceed one hundred twenty (120) beds, and the total number of beds that may be authorized in any Long-Term Care Planning District during any fiscal year shall not exceed forty (40) beds. Of the certificates of need that are issued for each Long-Term Care Planning District during the next two (2) fiscal years, at least one (1) shall be issued for beds in the northern part of the district, at least one (1) shall be issued for beds in the central part of the district, and at least one (1) shall be issued for beds in the southern part of the district.
(iii) The State Department of Health, in consultation with the Department of Mental Health and the Division of Medicaid, shall develop and prescribe the staffing levels, space requirements and other standards and requirements that must be met with regard to the nursing facility beds authorized under this paragraph (r) to provide care exclusively to patients with Alzheimer's disease.

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

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

(b) Of the total number of beds authorized under this subsection, the department may issue a certificate or certificates of need for the construction or expansion of psychiatric residential treatment facility beds or the conversion of other beds to psychiatric residential treatment facility beds in Warren County, not to exceed sixty (60) psychiatric residential treatment facility beds, provided that the facility agrees in writing that no more than thirty (30) of the beds at the psychiatric residential treatment facility will be certified for participation...
in the Medicaid program (Section 43-13-101 et seq.) for the use of
any patients other than those who are participating only in the
Medicaid program of another state, and that no claim will be
submitted to the Division of Medicaid for Medicaid reimbursement
for more than thirty (30) patients in the psychiatric residential
treatment facility in any day or for any patient in the
psychiatric residential treatment facility who is in a bed that is
not Medicaid-certified. This written agreement by the recipient
of the certificate of need shall be a condition of the issuance of
the certificate of need under this paragraph, and the agreement
shall be fully binding on any subsequent owner of the psychiatric
residential treatment facility if the ownership of the facility is
transferred at any time after the issuance of the certificate of
need. After this written agreement is executed, the Division of
Medicaid and the State Department of Health shall not certify more
than thirty (30) of the beds in the psychiatric residential
treatment facility for participation in the Medicaid program for
the use of any patients other than those who are participating
only in the Medicaid program of another state. If the psychiatric
residential treatment facility violates the terms of the written
agreement by admitting or keeping in the facility on a regular or
continuing basis more than thirty (30) patients who are
participating in the Mississippi Medicaid program, the State
Department of Health shall revoke the license of the facility, at
the time that the department determines, after a hearing complying
with due process, that the facility has violated the condition
upon which the certificate of need was issued, as provided in this
paragraph and in the written agreement.

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

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

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

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

(f) The department shall issue a certificate of need to
a one-hundred-thirty-four-bed specialty hospital located on
twenty-nine and forty-four one-hundredths (29.44) commercial acres
at 5900 Highway 39 North in Meridian (Lauderdale County),
Mississippi, for the addition, construction or expansion of
child/adolescent psychiatric residential treatment facility beds
in Lauderdale County. As a condition of issuance of the
certificate of need under this paragraph, the facility shall give
priority in admissions to the child/adolescent psychiatric
residential treatment facility beds authorized under this paragraph to patients who otherwise would require out-of-state placement. The Division of Medicaid, in conjunction with the Department of Human Services, shall furnish the facility a list of all out-of-state patients on a quarterly basis. Furthermore, notice shall also be provided to the parent, custodial parent or guardian of each out-of-state patient notifying them of the priority status granted by this paragraph. For purposes of this paragraph, the provisions of Section 41-7-193(1) requiring substantial compliance with the projection of need as reported in the current State Health Plan are waived. The total number of child/adolescent psychiatric residential treatment facility beds that may be authorized under the authority of this paragraph shall be sixty (60) beds. There shall be no prohibition or restrictions on participation in the Medicaid program (Section 43-13-101 et seq.) for the person receiving the certificate of need authorized under this paragraph or for the beds converted pursuant to the authority of that certificate of need.

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

(i) The department may issue certificates of need to any person for any purpose described in this subsection, provided that the hospital, psychiatric hospital or chemical dependency hospital does not participate in the Medicaid program (Section 43-13-101 et seq.) at the time of the application for the certificate of need and the owner of the hospital, psychiatric hospital or chemical dependency hospital agrees in writing that the hospital, psychiatric hospital or chemical dependency hospital will not at any time participate in the Medicaid program or admit or keep any patients who are participating in the Medicaid program in the hospital, psychiatric hospital or chemical dependency hospital. This written agreement by the recipient of the certificate of need shall be fully binding on any subsequent owner of the hospital, psychiatric hospital or chemical dependency hospital, if the ownership of the facility is transferred at any time after the issuance of the certificate of need. Agreement that the hospital, psychiatric hospital or chemical dependency hospital will not participate in the Medicaid program shall be a condition of the issuance of a certificate of need to any person under this subparagraph (a)(i), and if such hospital, psychiatric hospital or chemical dependency hospital at any time after the issuance of the certificate of need, regardless of the ownership of the facility, participates in the Medicaid program or admits or keeps any patients in the hospital, psychiatric hospital or chemical dependency hospital who are participating in the Medicaid program, the State Department of Health shall revoke the certificate of need, if it is still outstanding, and shall deny or revoke the license of the hospital, psychiatric hospital or chemical dependency hospital, at the time that the department determines, after a hearing complying with due process, that the hospital, psychiatric hospital or chemical dependency hospital has...
failed to comply with any of the conditions upon which the
certificate of need was issued, as provided in this subparagraph
and in the written agreement by the recipient of the certificate
of need.

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

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

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

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

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

(vi) The department may issue a certificate or certificates of need for the expansion of child psychiatric beds or the conversion of other beds to child psychiatric beds at the University of Mississippi Medical Center. For purposes of this subparagraph (a)(vi), the provision of Section 41-7-193(1) requiring substantial compliance with the projection of need as reported in the current State Health Plan is waived. The total number of beds that may be authorized under the authority of this subparagraph (a)(vi) shall not exceed fifteen (15) beds. There shall be no prohibition or restrictions on participation in the Medicaid program (Section 43-13-101 et seq.) for the hospital receiving the certificate of need authorized under this subparagraph (a)(vi) or for the beds converted pursuant to the authority of that certificate of need.
(b) From and after July 1, 1990, no hospital, psychiatric hospital or chemical dependency hospital shall be authorized to add any child/adolescent psychiatric or child/adolescent chemical dependency beds or convert any beds of another category to child/adolescent psychiatric or child/adolescent chemical dependency beds without a certificate of need under the authority of subsection (1)(c) of this section.

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

(6) The State Department of Health shall issue a certificate of need to a Mississippi corporation qualified to manage a long-term care hospital as defined in Section 41-7-173(h)(xii) in Harrison County, not to exceed eighty (80) beds, including any necessary renovation or construction required for licensure and certification, provided that the recipient of the certificate of need agrees in writing that the long-term care hospital will not at any time participate in the Medicaid program (Section 43-13-101 et seq.) or admit or keep any patients in the long-term care hospital who are participating in the Medicaid program. This written agreement by the recipient of the certificate of need shall be fully binding on any subsequent owner of the long-term care hospital, if the ownership of the facility is transferred at any time after the issuance of the certificate of need. Agreement that the long-term care hospital will not participate in the Medicaid program shall be a condition of the issuance of a certificate of need to any person under this subsection (6), and if such long-term care hospital at any time after the issuance of the certificate of need, regardless of the ownership of the facility, participates in the Medicaid program or admits or keeps any patients in the facility who are participating in the Medicaid program, the State Department of Health shall revoke the certificate of need, if it is still outstanding, and shall deny or
revoke the license of the long-term care hospital, at the time that the department determines, after a hearing complying with due process, that the facility has failed to comply with any of the conditions upon which the certificate of need was issued, as provided in this subsection and in the written agreement by the recipient of the certificate of need. For purposes of this subsection, the provision of Section 41-7-193(1) requiring substantial compliance with the projection of need as reported in the current State Health Plan is hereby waived.

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

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

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

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

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

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

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

(a) Before any construction or conversion may be undertaken without a certificate of need, the owner of the nursing facility, in the case of an existing facility, or the applicant to
construct a nursing facility, in the case of new construction, 
first must file a written notice of intent and sign a written 
agreement with the State Department of Health that the entire 
nursing facility will not at any time participate in or have any 
beds certified for participation in the Medicaid program (Section 
43-13-101 et seq.), will not admit or keep any patients in the 
nursing facility who are participating in the Medicaid program, 
and will not submit any claim for Medicaid reimbursement for any 
patient in the facility. This written agreement by the owner or 
applicant shall be a condition of exercising the authority under 
this subsection without a certificate of need, and the agreement 
shall be fully binding on any subsequent owner of the nursing 
facility if the ownership of the facility is transferred at any 
time after the agreement is signed. After the written agreement 
is signed, the Division of Medicaid and the State Department of 
Health shall not certify any beds in the nursing facility for 
participation in the Medicaid program. If the nursing facility 
violates the terms of the written agreement by participating in 
the Medicaid program, having any beds certified for participation 
in the Medicaid program, admitting or keeping any patient in the 
facility who is participating in the Medicaid program, or 
submitting any claim for Medicaid reimbursement for any patient in 
the facility, the State Department of Health shall revoke the 
license of the nursing facility at the time that the department 
determines, after a hearing complying with due process, that the 
facility has violated the terms of the written agreement.

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

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

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

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

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

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

(17) The State Department of Health shall issue, upon application therefor, a certificate of need to the sole Medicare certified hospital of at least one hundred fifty (150) licensed beds for comprehensive medical rehabilitation services as defined in Section 41-7-173(h)(xiii) in the following counties: Alcorn, Coahoma, Lafayette, Lowndes, Grenada, Jones and Jackson. The recipient hospital of the comprehensive medical rehabilitation services certificate of need shall agree in writing that the hospital will not participate in the Medicaid program, Section 43-13-101 et seq., for any patient admitted to the stated service.

SECTION 11. Section 43-13-407, Mississippi Code of 1972, is amended as follows:

43-13-407. (1) In accordance with the purposes of this article, there is established in the State Treasury the Health Care Expendable Fund, into which shall be transferred from the Health Care Trust Fund the following sums:

(a) In fiscal year 2000, Fifty Million Dollars ($50,000,000.00);
(b) In fiscal year 2001, Fifty-five Million Dollars ($55,000,000.00);
(c) In fiscal year 2002, Sixty Million Five Hundred Thousand Dollars ($60,500,000.00);
(d) In fiscal year 2003, Sixty-six Million Five Hundred Fifty Thousand Dollars ($66,550,000.00);
(e) In fiscal year 2004 and each subsequent fiscal year, a sum equal to the average annual amount of the income from the investment of the funds in the Health Care Trust Fund since July 1, 1999.

(2) In any fiscal year in which interest and dividends from the investment of the funds in the Health Care Trust Fund are not sufficient to fund the full amount of the annual transfer into the Health Care Expendable Fund as required in subsection (1) of this section, the State Treasurer shall transfer from tobacco settlement installment payments an amount that is sufficient to fully fund the amount of the annual transfer.

(3) The State Treasurer shall transfer One Hundred Million Dollars ($100,000,000.00) of the 2002 tobacco settlement installment payment, and up to One Hundred Million Dollars ($100,000,000.00) of the future annual tobacco settlement installment payments, into the Health Care Expendable Fund, and said monies shall be appropriated by the Legislature to the Division of Medicaid to match federal funds pursuant to the federal waiver programs authorized in Sections 43-13-115 and 43-13-117, Mississippi Code of 1972.

(4) All income from the investment of the funds in the Health Care Expendable Fund shall be credited to the account of the Health Care Expendable Fund. Any funds in the Health Care Expendable Fund at the end of a fiscal year shall not lapse into the State General Fund.

(5) The funds in the Health Care Expendable Fund shall be available for expenditure pursuant to specific appropriation by the Legislature beginning in fiscal year 2000, and shall be expended exclusively for health care purposes.

SECTION 12. Section 43-13-405, Mississippi Code of 1972, is amended as follows:

43-13-405. (1) In accordance with the purposes of this article, there is established in the State Treasury the Health
Care Trust Fund, into which shall be deposited Two Hundred Eighty Million Dollars ($280,000,000.00) of the funds received by the State of Mississippi as a result of the tobacco settlement as of the end of fiscal year 1999, and all tobacco settlement installment payments made in subsequent years for which the use or purpose for expenditure is not restricted by the terms of the settlement, except as otherwise provided in Sections 43-13-407(2) and 43-13-407(3). All income from the investment of the funds in the Health Care Trust Fund shall be credited to the account of the Health Care Trust Fund. The funds in the Health Care Trust Fund at the end of a fiscal year shall not lapse into the State General Fund.

(2) The Health Care Trust Fund shall remain inviolate and shall never be expended, except as provided in this article. The Legislature shall appropriate from the Health Care Trust Fund such sums as are necessary to recoup any funds lost as a result of any of the following actions:

(a) The federal Health Care Finance Administration, or other agency of the federal government, is successful in recouping tobacco settlement funds from the State of Mississippi;

(b) The federal share of funds for the support of the Mississippi Medicaid Program is reduced directly or indirectly as a result of the tobacco settlement;

(c) Federal funding for any other program is reduced as a result of the tobacco settlement; or

(d) Tobacco cessation programs are mandated by the federal government or court order.

SECTION 13. This act shall take effect and be in force from and after July 1, 2002.