AN ACT RELATING TO THE MISSISSIPPI MEDICAID LAW AND PROVIDING
HEALTH CARE; TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
TO AUTHORIZE UNLIMITED DAY REIMBURSEMENT FOR DISPROPORTIONATE
SHARE PROGRAM HOSPITALS FOR ELIGIBLE CHILDREN UNDER THE AGE OF SIX
ONLY IF CERTIFIED AS MEDICALLY NECESSARY, TO AUTHORIZE THE
DIVISION OF MEDICAID TO ESTABLISH A MEDICARE UPPER PAYMENT LIMITS
PROGRAM FOR OUTPATIENT HOSPITAL SERVICES, TO AUTHORIZE THE
DIVISION OF MEDICAID TO ESTABLISH A MEDICARE UPPER PAYMENT LIMITS
PROGRAM FOR NURSING FACILITY SERVICES, TO REQUIRE THAT NURSING
FACILITIES THAT PARTICIPATE IN THE MEDICAID PROGRAM ALSO BE
CERTIFIED TO PARTICIPATE IN THE MEDICARE PROGRAM, TO DELETE
SPECIFIC FEE INCREASES FOR PERIODIC SCREENING AND DIAGNOSTIC
SERVICES, TO REVISE THE CONDITIONS FOR REIMBURSEMENT OF THE COST
OF EYGLASSES FOR RECIPIENTS, TO CLARIFY THE REQUIREMENT FOR
DISPROPORTIONATE SHARE PROGRAM HOSPITALS TO PARTICIPATE IN THE
FEDERAL INTERGOVERNMENTAL TRANSFER PROGRAM, TO CHANGE CERTAIN
REFERENCES TO THE FEDERAL INDIVIDUALS WITH DISABILITIES EDUCATION
ACT, TO AUTHORIZE MEDICAID REIMBURSEMENT TO RURAL HEALTH CENTERS
FOR AMBULATORY SERVICES, TO AUTHORIZE MEDICAID REIMBURSEMENT TO
CHIROPRACTORS FOR X-RAYS PERFORMED TO DOCUMENT CONDITIONS, AND TO
AUTHORIZE THE DIVISION TO DEVELOP AND IMPLEMENT A DISEASE
MANAGEMENT PROGRAM; TO AMEND SECTION 43-13-121, MISSISSIPPI CODE
OF 1972, TO CLARIFY AND REVISE THE CONDITIONS FOR DENYING OR
REVOKING PROVIDER ENROLLMENT IN THE MEDICAID PROGRAM; TO AMEND
SECTION 43-13-123, MISSISSIPPI CODE OF 1972, TO CLARIFY THAT THE
DIVISION SHALL OBTAIN SERVICES PURSUANT TO REGULATIONS OF THE
PERSONAL SERVICE CONTRACT REVIEW BOARD; TO AMEND SECTION
43-13-145, MISSISSIPPI CODE OF 1972, TO CLARIFY THAT THE MEDICAID
ASSESSMENT IS TO BE ON ALL LICENSED OR CERTIFIED NURSING FACILITY
BEDS IN THE STATE; TO AMEND SECTION 41-7-191, MISSISSIPPI CODE OF
1972, TO DELETE THE REQUIREMENT THAT THE DIVISION OF MEDICAID
FURNISH A CERTAIN RESIDENTIAL FACILITY THE NAMES AND MEDICAL
INFORMATION ABOUT RECIPIENTS RECEIVING SERVICES OUT OF STATE; TO
AMEND SECTIONS 43-11-19 AND 43-63-21, MISSISSIPPI CODE OF 1972, TO
CLARIFY THAT NURSING HOME SURVEYS AND REPORTS SHALL BE
CONFIDENTIAL EXCEPT IN ADMINISTRATIVE LICENSURE CASES; TO AMEND
SECTION 43-11-13, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT
NOTHING IN THE NURSING HOME STATUTES OR REGULATIONS SHALL
ESTABLISH A MEDICAL STANDARD OF CARE; TO AMEND SECTION 15-1-36,
MISSISSIPPI CODE OF 1972, TO ESTABLISH A LONG-TERM CARE STATUTE OF
LIMITATIONS; TO AMEND SECTION 43-11-7, MISSISSIPPI CODE OF 1972,
TO CLARIFY APPLICANTS FOR A NURSING HOME LICENSE; TO AMEND
SECTIONS 43-7-53 AND 43-7-61, MISSISSIPPI CODE OF 1972, TO CLARIFY
QUALIFICATIONS FOR LONG-TERM CARE OMBUDSMEN; TO PROVIDE VENUE FOR
BRINGING A CAUSE OF ACTION AGAINST NURSING HOMES AND OTHER
LONG-TERM CARE PROVIDERS; AND FOR RELATED PURPOSES.

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

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

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 if certified as medically necessary as required by the division.

(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.

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

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

(3) Laboratory and x-ray services.

(4) Nursing facility services.

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

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

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

(d) When a facility of a category that does not require a certificate of need for construction and that could not be eligible for Medicaid reimbursement is constructed to nursing facility specifications for licensure and certification, and the facility is subsequently converted to a nursing facility pursuant to a certificate of need that authorizes conversion only and the applicant for the certificate of need was assessed an application review fee based on capital expenditures incurred in constructing the facility, the division shall allow reimbursement for capital expenditures necessary for construction of the facility that were incurred within the twenty-four (24) consecutive calendar months immediately preceding the date that the certificate of need authorizing such conversion was issued, to the same extent that reimbursement would be allowed for construction of a new nursing facility pursuant to a certificate of need that authorizes such construction. The reimbursement authorized in this subparagraph (d) may be made only to facilities the construction of which was completed after June 30, 1989. Before the division shall be authorized to make the reimbursement authorized in this subparagraph (d), the division first must have received approval from the Health Care Financing Administration of the United States Department of Health and Human Services of the change in the state Medicaid plan providing for such reimbursement.
(e) The division shall develop and implement, not later than January 1, 2001, a case-mix payment add-on determined by time studies and other valid statistical data which will reimburse a nursing facility for the additional cost of caring for a resident who has a diagnosis of Alzheimer's or other related dementia and exhibits symptoms that require special care. Any such case-mix add-on payment shall be supported by a determination of additional cost. The division shall also develop and implement as part of the fair rental reimbursement system for nursing facility beds, an Alzheimer's resident bed depreciation enhanced reimbursement system which will provide an incentive to encourage nursing facilities to convert or construct beds for residents with Alzheimer's or other related dementia.

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

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

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

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

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

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

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

The division shall make full payment for long-term care alternative services.
The division shall apply for necessary federal waivers to assure that additional services providing alternatives to nursing facility care are made available to applicants for nursing facility care.

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

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

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

* * *

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

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

(b) Repealed.

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

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

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

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

The division shall develop and implement a program of payment for additional pharmacist services, with payment to be based on demonstrated savings, but in no case shall the total payment exceed twice the amount of the dispensing fee.
As used in this paragraph (9), "estimated acquisition cost" means the division's best estimate of what price providers generally are paying for a drug in the package size that providers buy most frequently. Product selection shall be made in compliance with existing state law; however, the division may reimburse as if the prescription had been filled under the generic name. The division may provide otherwise in the case of specified drugs when the consensus of competent medical advice is that tradmarked drugs are substantially more effective.

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

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

(12) Intermediate care facility services.

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

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

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

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

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

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

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

(18) (a) Notwithstanding any other provision of this section to the contrary, the division shall make additional reimbursement to hospitals which serve a disproportionate share of low-income patients and which meet the federal requirements for such payments as provided in Section 1923 of the federal Social Security Act and any applicable regulations. However, from and after January 1, 1999, no public hospital shall participate in the Medicaid disproportionate share program unless the public hospital participates in an intergovernmental transfer program as provided in Section 1903 of the federal Social Security Act and any applicable regulations. Administration and support for participating hospitals shall be provided by the Mississippi Hospital Association.
(b) The division shall establish a Medicare Upper Payment Limits Program as defined in Section 1902 (a) (30) of the federal Social Security Act and any applicable federal regulations. The division shall assess each hospital for the sole purpose of financing the state portion of the Medicare Upper Payment Limits Program. This assessment shall be based on Medicaid utilization, or other appropriate method consistent with federal regulations, and will remain in effect as long as the state participates in the Medicare Upper Payment Limits Program. The division shall make additional reimbursement to hospitals for the Medicare Upper Payment Limits as defined in Section 1902 (a) (30) of the federal Social Security Act and any applicable federal regulations. This paragraph (b) shall stand repealed from and after July 1, 2005.

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

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

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

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

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

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

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

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

(25) Birthing center services.

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

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

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

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

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

(31) Targeted case management services for children
with special needs, under waivers from the United States
Department of Health and Human Services, using state funds that
are provided from the appropriation to the Mississippi Department
of Human Services and used to match federal funds under a
cooperative agreement between the division and the department.
(32) Care and services provided in Christian Science
Sanatoria operated by or listed and certified by The First Church of Christ Scientist, Boston, Massachusetts, rendered in connection with treatment by prayer or spiritual means to the extent that such services are subject to reimbursement under Section 1903 of the Social Security Act.

(33) Podiatrist services.

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

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

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

(37) [Deleted]

(38) Chiropractic services: a chiropractor's manual manipulation of the spine to correct a subluxation, if x-ray demonstrates that a subluxation exists and if the subluxation has resulted in a neuromusculoskeletal condition for which manipulation is appropriate treatment, and related spinal x-rays performed to document these conditions. Reimbursement for chiropractic services shall not exceed Seven Hundred Dollars ($700.00) per year per beneficiary.
(39) Dually eligible Medicare/Medicaid beneficiaries. The division shall pay the Medicare deductible and ten percent (10%) coinsurance amounts for services available under Medicare for the duration and scope of services otherwise available under the Medicaid program.

(40) [Deleted]

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

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

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

(44) Nursing facility services for the severely disabled.
(a) Severe disabilities include, but are not limited to, spinal cord injuries, closed head injuries and ventilator dependent patients.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) In suspending or terminating any provider from
participation in the Medicaid program, the division shall preclude
such provider from submitting claims for payment, either
personally or through any clinic, group, corporation or other
association to the division or its fiscal agents for any services
or supplies provided under the Medicaid program except for those
services or supplies provided prior to the suspension or
termination. No clinic, group, corporation or other association
which is a provider of services shall submit claims for payment to
the division or its fiscal agents for any services or supplies provided by a person within such organization who has been suspended or terminated from participation in the Medicaid program except for those services or supplies provided prior to the suspension or termination. When this provision is violated by a provider of services which is a clinic, group, corporation or other association, the division may suspend or terminate such organization from participation. Suspension may be applied by the division to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances.

The violation, failure, or inadequacy of performance may be imputed to a person with whom the provider is affiliated where such conduct was accomplished with the course of his official duty or was effectuated by him with the knowledge or approval of such person.

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

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

(b) Previous or current exclusion, suspension, termination from or the involuntary withdrawing from participation in, the Medicaid program, any other state's Medicaid program, Medicare or any other public or private health or health insurance program. If the division ascertains that a provider has been convicted of a felony under federal or state law for an offense which the division determines is detrimental to the best interest
of the program or of Medicaid beneficiaries, the division may
refuse to enter into an agreement with such provider, or may
terminate or refuse to renew an existing agreement.
(c) Conviction under federal or state law of a criminal
offense relating to the delivery of any goods, services or
supplies, including the performance of management or
administrative services relating to the delivery of the goods,
services or supplies, under the Medicaid program, any other
state's Medicaid program, Medicare or any other public or private
health or health insurance program.
(d) Conviction under federal or state law of a criminal
offense relating to the neglect or abuse of a patient in
connection with the delivery of any goods, services or supplies.
(e) Conviction under federal or state law of a criminal
offense relating to the unlawful manufacture, distribution,
prescription, or dispensing of a controlled substance.
(f) Conviction under federal or state law of a criminal
offense relating to fraud, theft, embezzlement, breach of
fiduciary responsibility or other financial misconduct.
(g) Conviction under federal or state law of a criminal
offense punishable by imprisonment of a year or more which
involves moral turpitude, or acts against the elderly, children or
infirm.
(h) Conviction under federal or state law of a criminal
offense in connection with the interference or obstruction of any
investigation into any criminal offense listed in paragraphs (c)
through (i) of this subsection.
(i) Sanction pursuant to a violation of federal or
state laws or rules relative to the Medicaid program, any other
state's Medicaid program, Medicare or any other public health care
or health insurance program.
(j) Violation of licensing or certification conditions
or professional standards relating to the licenses or
certification of providers or the required quality of goods, services or supplies provided.

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

(l) Failure to meet any condition of enrollment.

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

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

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

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

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

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

SECTION 4. Section 43-13-145, Mississippi Code of 1972, is amended as follows:
43-13-145. (1) Upon each nursing facility licensed or certified by the State of Mississippi and each intermediate care facility for the mentally retarded licensed by the State of Mississippi, there is levied an assessment in an amount set by the division not exceeding Two Dollars ($2.00) per day, or fraction thereof, for each licensed or certified bed of the facility. The division may apply for a waiver from the U.S. Secretary of Health and Human Services to exempt nonprofit, public, charitable or religious facilities from the assessment levied under this subsection, and if a waiver is granted, such facilities shall be exempt from any assessment levied under this subsection after the date that the division receives notice that the waiver has been granted.

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

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

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

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

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

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

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

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

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

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

(i) Open heart surgery services;

(ii) Cardiac catheterization services;

(iii) Comprehensive inpatient rehabilitation services;

(iv) Licensed psychiatric services;

(v) Licensed chemical dependency services;

(vi) Radiation therapy services;

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

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

(ix) Home health services;

(x) Swing-bed services;

(xi) Ambulatory surgical services;

(xii) Magnetic resonance imaging services;

(xiii) Extracorporeal shock wave lithotripsy services;

(xiv) Long-term care hospital services;

(xv) Positron Emission Tomography (PET) services;

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

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

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

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

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

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

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

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

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

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

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the facility on July 1, 2001, agrees in writing that no more than thirty (30) of the beds at the facility will be certified for participation in the Medicaid program, and that no claim will be submitted for Medicaid reimbursement for more than thirty (30) patients in the facility in any month or for any patient in the facility who is in a bed that is not Medicaid-certified. This written agreement by the owner of the facility shall be a condition of licensure of the facility, and the agreement shall be fully binding on any subsequent owner of the facility if the ownership of the facility is transferred at any time after July 1, 2001. After this written agreement is executed, the Division of Medicaid and the State Department of Health shall not certify more than thirty (30) of the beds in the facility for participation in the Medicaid program. If the facility violates the terms of the written agreement by admitting or keeping in the facility on a regular or continuing basis more than thirty (30) patients who are participating in the Medicaid program, the State Department of Health shall revoke the license of the facility, at the time that the department determines, after a hearing complying with due process, that the facility has violated the written agreement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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subparagraph (a)(v), and if such hospital at any time after the issuance of the certificate of need, regardless of the ownership of the hospital, has any of such adult psychiatric beds certified for participation in the Medicaid program or admits or keeps any Medicaid patients in such adult psychiatric beds, the State Department of Health shall revoke the certificate of need, if it is still outstanding, and shall deny or revoke the license of the hospital at the time that the department determines, after a hearing complying with due process, that the hospital has failed to comply with any of the conditions upon which the certificate of need was issued, as provided in this subparagraph and in the written agreement by the recipient of the certificate of need.

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

(b) From and after July 1, 1990, no hospital, psychiatric hospital or chemical dependency hospital shall be authorized to add any child/adolescent psychiatric or child/adolescent chemical dependency beds or convert any beds of another category to child/adolescent psychiatric or child/adolescent chemical dependency beds without a certificate of need under the authority of subsection (1)(c) of this section.
(5) The department may issue a certificate of need to a county hospital in Winston County for the conversion of fifteen (15) acute care beds to geriatric psychiatric care beds.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(16) Nothing in this section or in any other provision of Section 41-7-171 et seq. shall prevent any nursing facility from designating an appropriate number of existing beds in the facility as beds for providing care exclusively to patients with Alzheimer's disease.
SECTION 6. Section 43-11-19, Mississippi Code of 1972, is amended as follows:

43-11-19. Information received or caused to be maintained or collected by the licensing agency through filed reports, inspection, or as otherwise authorized under this chapter, shall not be disclosed by any person or party except in a proceeding involving the questions of licensure; however, the licensing agency may utilize statistical data concerning types of services and the utilization of those services for institutions for the aged or infirm in performing the statutory duties imposed upon it by Section 41-7-171, et seq. and by Section 43-11-21.

SECTION 7. Section 41-63-21, Mississippi Code of 1972, is amended as follows:

41-63-21. The term "accreditation and quality assurance materials" as used in Sections 41-63-21 through 41-63-29 means and shall include written reports, records, correspondence and materials concerning the accreditation or quality assurance of any hospital, nursing home or other health care facility and any medical care foundation, health maintenance organization, preferred provider organization, individual practice association or similar entity. * * * The confidentiality established by Sections 41-63-21 through 41-63-29 shall apply to accreditation and quality assurance materials prepared by an employee, advisor or consultant of any hospital, nursing home or other health care facility and any medical care foundation, health maintenance organization, preferred provider organization, individual practice association or similar entity and to materials provided by an employee, advisor or consultant of an accreditation, quality assurance or similar agency or similar body and to any individual who is an employee, advisor or consultant of a hospital, nursing home or other health care facility and any medical care foundation, health maintenance organization, preferred provider organization, individual practice association or similar entity or
accréditant, qualité assurance or similar agency or body. The
confidentiality established by Sections 41-63-21 through 41-63-29
shall apply to reports, records, correspondence and material
concerning accreditation or quality assurance that are prepared by
the State Department of Health except that if the State Department
of Health determines that substantial noncompliance with licensure
standards exists or that deficiencies that represent a threat to
public safety or patient care exist, the department shall prepare
a written summary of the substantial noncompliance or deficiencies
and the health care provider's response to the department's
determination, and the department's written summary and the health
care provider's response thereto shall be considered public
documents.

SECTION 8. Section 43-11-13, Mississippi Code of 1972, is
amended as follows:

43-11-13. (1) The licensing agency shall adopt, amend,
promulgate and enforce such rules, regulations and standards,
including classifications, with respect to all institutions for
the aged or infirm to be licensed under this chapter as may be
designed to further the accomplishment of the purpose of this
chapter in promoting adequate care of individuals in such
institutions in the interest of public health, safety and welfare.
Nothing contained in these or any other rules, regulations and
standards promulgated or enforced by the State Board of Health
should be construed as establishing a medical standard of care.
Such rules, regulations and standards shall be adopted and
promulgated by the licensing agency and shall be recorded and
indexed in a book to be maintained by the licensing agency in its
main office in the State of Mississippi, entitled "Rules,
Regulations and Minimum Standards for Institutions for the Aged or
Infirm" and the book shall be open and available to all
institutions for the aged or infirm and the public generally at
all reasonable times. Upon the adoption of such rules,
regulations and standards, the licensing agency shall mail copies thereof to all such institutions in the state which have filed with the agency their names and addresses for this purpose, but the failure to mail the same or the failure of the institutions to receive the same shall in no way affect the validity thereof. The rules, regulations and standards may be amended by the licensing agency, from time to time, as necessary to promote the health, safety and welfare of persons living in those institutions.

(2) The licensee shall keep posted in a conspicuous place on the licensed premises all current rules, regulations and minimum standards applicable to fire protection measures as adopted by the licensing agency. The licensee shall furnish to the licensing agency at least once each six (6) months a certificate of approval and inspection by state or local fire authorities. Failure to comply with state laws and/or municipal ordinances and current rules, regulations and minimum standards as adopted by the licensing agency, relative to fire prevention measures, shall be prima facie evidence for revocation of license.

(3) The State Board of Health shall promulgate rules and regulations restricting the storage, quantity and classes of drugs allowed in personal care homes. Residents requiring administration of Schedule II Narcotics as defined in the Uniform Controlled Substances Law may be admitted to a personal care home. Schedule drugs may only be allowed in a personal care home if they are administered or stored utilizing proper procedures under the direct supervision of a licensed physician or nurse.

(4) (a) Notwithstanding any determination by the licensing agency that skilled nursing services would be appropriate for a resident of a personal care home, that resident, the resident's guardian or the legally recognized responsible party for the resident may consent in writing for the resident to continue to reside in the personal care home, if approved in writing by a licensed physician. Provided, however, that no personal care home
shall allow more than two (2) residents, or ten percent (10%) of
the total number of residents in the facility, whichever is
greater, to remain in the personal care home under the provisions
of this subsection (4). This consent shall be deemed to be
appropriately informed consent as described in the regulations
promulgated by the licensing agency. After that written consent
has been obtained, the resident shall have the right to continue
to reside in the personal care home for as long as the resident
meets the other conditions for residing in the personal care home.
A copy of the written consent and the physician's approval shall
be forwarded by the personal care home to the licensing agency.

(b) The State Board of Health shall promulgate rules
and regulations restricting the handling of a resident's personal
deposits by the director of a personal care home. Any funds given
or provided for the purpose of supplying extra comforts,
conveniences or services to any patient in any personal care home,
and any funds otherwise received and held from, for or on behalf
of any such resident, shall be deposited by the director or other
proper officer of the personal care home to the credit of that
patient in an account which shall be known as the Resident's
Personal Deposit Fund. No more than one (1) month charge for the
care, support, maintenance and medical attention of the patient
shall be applied from such account at any one (1) time. After the
death, discharge or transfer of any resident for whose benefit any
such fund has been provided, any unexpended balance remaining in
his personal deposit fund shall be applied for the payment of
care, cost of support, maintenance and medical attention which is
accrued. In the event any unexpended balance remains in that
resident's personal deposit fund after complete reimbursement has
been made for payment of care, support, maintenance and medical
attention, and the director or other proper officer of the
personal care home has been or shall be unable to locate the
person or persons entitled to such unexpended balance, the
director or other proper officer may, after the lapse of one (1) year from the date of such death, discharge or transfer, deposit the unexpended balance to the credit of the personal care home's operating fund.

(c) The State Board of Health shall promulgate rules and regulations requiring personal care homes to maintain records relating to health condition, medicine dispensed and administered, and any reaction to such medicine. The director of the personal care home shall be responsible for explaining the availability of such records to the family of the resident at any time upon reasonable request.

(d) The State Board of Health shall evaluate the effects of this section as it promotes adequate care of individuals in personal care homes in the interest of public health, safety and welfare. It shall report its findings to the Chairmen of the Public Health and Welfare Committees of the House and Senate by January 1, 2003. This subsection (4) shall stand repealed June 30, 2003.

(5) (a) Pursuant to regulations promulgated by the State Department of Health, the licensing agency shall require to be performed a criminal history record check on every new employee of a licensed institution for the aged or infirm or care facility who provides direct patient care or services and who is employed after July 1, 2001. Except as otherwise provided, no such new employee shall be permitted to provide direct patient care or services until the results of the criminal history record check have revealed no disqualifying record. Every such new employee shall provide a valid current social security number and/or driver's license number which shall be furnished to the licensing agency or to the private entity designated by the licensing agency to conduct the criminal history record check. The institution for the aged or infirm or care facility applying for the criminal history record check will be promptly notified of any
disqualifying record found by the criminal history record check. In order to determine the applicant's suitability for employment, the applicant shall be fingerprinted. If no disqualifying record is identified at the state level, the fingerprints shall be forwarded by the Department of Public Safety to the Federal Bureau of Investigation for a national criminal history record check.

(b) A licensed institution for the aged or infirm or care facility may make an offer of temporary employment to a prospective employee pending the results of a criminal history record check on the person. In such instances, the licensed institution for the aged or infirm or care facility shall provide to the licensing agency, or to the designated private entity, the name and relevant information relating to the person within seventy-two (72) hours after the date the person accepts temporary employment.

(c) All fees incurred in compliance with this section shall be borne by the institution or facility requesting the criminal history record check. The licensing agency, or the designated private entity, is authorized to charge the institution for the aged or infirm or care facility a fee which shall include the amount required by the Mississippi Department of Public Safety, the Federal Bureau of Investigation or any other agency designated by the licensing agency for the national criminal history record check in addition to any necessary costs incurred by the licensing agency or the designated private entity for the handling and administration of the criminal history record checks. Costs incurred by a nursing home provider implementing this act shall be reimbursed as an allowable cost under Section 43-13-116.

(d) The licensing agency, care facility, and their agents, officers, employees, attorneys and representatives shall be presumed to be acting in good faith for any employment decision or action taken under paragraphs (a) and (b) of this subsection.
The presumption of good faith may be overcome by a preponderance of the evidence in any civil action.

(e) The licensing agency shall promulgate regulations to implement this subsection (5).

SECTION 9. Section 15-1-36, Mississippi Code of 1972, is amended as follows:

15-1-36. (1) For any claim accruing on or before June 30, 1998, and except as otherwise provided in this section, no claim in tort may be brought against a licensed physician, osteopath, dentist, hospital or nursing home or other long-term care facility, nurse, pharmacist, podiatrist, optometrist or chiropractor for injuries or wrongful death arising out of the course of medical, surgical or other professional services unless it is filed within two (2) years from the date the alleged act, omission or neglect shall or with reasonable diligence might have been first known or discovered.

(2) For any claim accruing on or after July 1, 1998, and except as otherwise provided in this section, no claim in tort may be brought against a licensed physician, osteopath, dentist, hospital or nursing home or other long-term care hospital, nurse, pharmacist, podiatrist, optometrist or chiropractor for injuries or wrongful death arising out of the course of medical, surgical or other professional services unless it is filed within two (2) years from the date the alleged act, omission or neglect shall or with reasonable diligence might have been first known or discovered, and, except as described in paragraphs (a) and (b) of this subsection, in no event more than seven (7) years after the alleged act, omission or neglect occurred:

(a) In the event a foreign object introduced during a surgical or medical procedure has been left in a patient's body, the cause of action shall be deemed to have first accrued at, and not before, the time at which the foreign object is, or with
reasonable diligence should have been, first known or discovered to be in the patient's body.

(b) In the event the cause of action shall have been fraudulently concealed from the knowledge of the person entitled thereto, the cause of action shall be deemed to have first accrued at, and not before, the time at which such fraud shall be, or with reasonable diligence should have been, first known or discovered.

(3) Except as otherwise provided in subsection (4) of this section, if at the time at which the cause of action shall or with reasonable diligence might have been first known or discovered, the person to whom such claim has accrued shall be six (6) years of age or younger, then such minor or the person claiming through such minor may, notwithstanding that the period of time limited pursuant to subsections (1) and (2) of this section shall have expired, commence action on such claim at any time within two (2) years next after the time at which the minor shall have reached his sixth birthday, or shall have died, whichever shall have first occurred.

(4) If at the time at which the cause of action shall or with reasonable diligence might have been first known or discovered, the person to whom such claim has accrued shall be a minor without a parent or legal guardian, then such minor or the person claiming through such minor may, notwithstanding that the period of time limited pursuant to subsections (1) and (2) of this section shall have expired, commence action on such claim at any time within two (2) years next after the time at which the minor shall have a parent or legal guardian or shall have died, whichever shall have first occurred; provided, however, that in no event shall the period of limitation begin to run prior to such minor's sixth birthday unless such minor shall have died.

(5) If at the time at which the cause of action shall or with reasonable diligence might have been first known or discovered, the person to whom such claim has accrued shall be
under the disability of unsoundness of mind, then such person or
the person claiming through him may, notwithstanding that the
period of time hereinbefore limited shall have expired, commence
action on such claim at any time within two (2) years next after
the time at which the person to whom the right shall have first
accrued shall have ceased to be under the disability, or shall
have died, whichever shall have first occurred.

(6) When any person who shall be under the disabilities
mentioned in subsections (3), (4) and (5) of this section at the
time at which his right shall have first accrued, shall depart
this life without having ceased to be under such disability, no
time shall be allowed by reason of the disability of such person
to commence action on the claim of such person beyond the period
prescribed under Section 15-1-55, Mississippi Code of 1972.

(7) For the purposes of subsection (3) of this section, and
only for the purposes of such subsection, the disability of
infancy or minority shall be removed from and after a person has
reached his sixth birthday.

(8) For the purposes of subsection (4) of this section, and
only for the purposes of such subsection, the disability of
infancy or minority shall be removed from and after a person has
reached his sixth birthday or from and after such person shall
have a parent or legal guardian, whichever occurs later, unless
such disability is otherwise removed by law.

(9) The limitation established by this section as to a
licensed physician, osteopath, dentist, hospital or nurse shall
apply only to actions the cause of which accrued on or after July
1, 1976.

(10) The limitation established by this section as to
pharmacists shall apply only to actions the cause of which accrued
on or after July 1, 1978.
(11) The limitation established by this section as to podiatrists shall apply only to actions the cause of which accrued on or after July 1, 1979.

(12) The limitation established by this section as to optometrists and chiropractors shall apply only to actions the cause of which accrued on or after July 1, 1983.

(13) The limitation established by this section as to actions commenced on behalf of minors shall apply only to actions the cause of which accrued on or after July 1, 1989.

SECTION 10. Section 43-11-7, Mississippi Code of 1972, is amended as follows:

43-11-7. Any person, as defined in this chapter, may apply for a license as provided herein. An application for a license shall be made to the licensing agency upon forms provided by it and shall contain such information as the licensing agency reasonably requires, which may include affirmative evidence of ability to comply with such reasonable standards, rules and regulations as are lawfully prescribed hereunder. Each application for a license for an institution for the aged or infirm, except for personal care homes, shall be accompanied by a license fee of Twenty Dollars ($20.00) for each bed in the institution, with a minimum fee per institution of Two Hundred Dollars ($200.00), which shall be paid to the licensing agency. Each application for a license for a personal care home shall be accompanied by a license fee of Fifteen Dollars ($15.00) for each bed in the institution, with a minimum fee per institution of One Hundred Dollars ($100.00), which shall be paid to the licensing agency.

No governmental entity or agency shall be required to pay the fee or fees set forth in this section.

SECTION 11. Section 43-7-53, Mississippi Code of 1972, is amended as follows:
43-7-53. (1) There is hereby established within the Mississippi Council on Aging, the Office of the State Long-Term Care Facilities Ombudsman as provided by the Older Americans Act of 1965, as amended, 42 USCS 3001.

(2) The council shall establish the qualifications of state and community ombudsmen. Such qualifications shall include training and experience with long-term care facilities.

SECTION 12. Section 43-7-61, Mississippi Code of 1972, is amended as follows:

43-7-61. (1) The Office of the State Long-Term Care Facilities Ombudsman shall establish a training and certification program. The council shall specify by rule the content of the training program. Each long-term care facilities ombudsman program shall bear the cost of training its own employees.

(2) The State Ombudsman shall arrange for the training of all prospective community ombudsmen selected by area agencies on aging. Such training shall include instruction in at least the following subjects as they relate to long-term care:

(a) The responsibilities and duties of community ombudsmen;

(b) The laws and regulations governing the receipt, investigation and resolution of issues of the well-being of a resident;

(c) The role of local, state and federal agencies that regulate long-term care facilities;

(d) The different kinds of long-term care facilities in Mississippi and the services provided in each kind;

(e) The special needs of the elderly and of the physically and mentally handicapped;

(f) The role of the family, the sponsor, the legal representative, the physician, the church, and other public and private agencies, and the community;

(g) How to work with long-term care facility staff;
(h) The aging process and characteristics of the long-term care facility resident or institutionalized elderly;

(i) Familiarity with and access to information concerning the laws and regulations governing Medicare, Medicaid, Social Security, Supplemental Security Income, the Veterans Administration and Workers' Compensation; and

(j) The training program shall include an appropriate internship to be performed in a long-term care facility.

(3) Persons selected by area agencies on aging who have satisfactorily completed the training arranged by the State Ombudsman shall be certified as community ombudsmen by the council.

(4) Each area agency on aging may appoint an advisory committee to advise it in the operation of its community ombudsman program. The number and qualifications of members of the advisory committee shall be determined by the area agency on aging.

(5) Ombudsmen who have successfully completed the training and certification program under this section shall be given identification cards which shall be presented to employees of a long-term care facility upon request.

(6) Ombudsmen shall participate in ongoing training programs related to their duties or responsibilities.

SECTION 13. Actions against nursing homes and other long-term care providers for injury or damages or wrongful death whether in contract or tort-based on an alleged breach of the standard of care must be brought in the county wherein the act or omission constituting the alleged breach of the standard of care by the defendant actually occurred. If the act or omissions took place in more than one (1) county within the State of Mississippi, the action must be brought in the county wherein the plaintiff resided at the time of the act or omission, if the action is one for personal injuries, or wherein the plaintiff's decedent resided at the time of the act or omission if the action is one for
wrongful death. If at any time prior to the commencement of the trial of the action it is shown that the plaintiff's injuries or plaintiff's decedent's death did not result from acts or omissions which took place in more than one (1) county, on motion of any defendant the court shall transfer the action to such county wherein the alleged acts or omissions actually occurred. If an action is brought in an improper county, such action may be transferred to the proper county pursuant to Section 11-11-17.

SECTION 14. This act shall take effect and be in force from and after its passage.