

REPORT OF CONFERENCE COMMITTEE

MADAM PRESIDENT AND MR. SPEAKER:

We, the undersigned conferees, have had under consideration the amendments to the following entitled BILL:

S. B. No. 2189: Mississippi Medicaid Law; make technical amendments to.

We, therefore, respectfully submit the following report and recommendation:

1. That the House recede from its Amendment No. 1.

2. That the Senate and House adopt the following amendment:

Amend by striking all after the enacting clause and inserting in lieu thereof the following:

62 **SECTION 1.** Section 43-13-117, Mississippi Code of 1972, as
63 amended by House Bill No. 1200 and Senate Bill No. 3060, 2002
64 Regular Session, is amended as follows:

65 43-13-117. Medicaid as authorized by this article shall
66 include payment of part or all of the costs, at the discretion of
67 the division or its successor, with approval of the Governor, of
68 the following types of care and services rendered to eligible
69 applicants who have been determined to be eligible for that care
70 and services, within the limits of state appropriations and
71 federal matching funds:

72 (1) Inpatient hospital services.

73 (a) The division shall allow thirty (30) days of
74 inpatient hospital care annually for all Medicaid recipients.
75 Precertification of inpatient days must be obtained as required by
76 the division. The division may allow unlimited days in
77 disproportionate hospitals as defined by the division for eligible
78 infants under the age of six (6) years if certified as medically
79 necessary as required by the division.

80 (b) From and after July 1, 1994, the Executive
81 Director of the Division of Medicaid shall amend the Mississippi
82 Title XIX Inpatient Hospital Reimbursement Plan to remove the
83 occupancy rate penalty from the calculation of the Medicaid

84 Capital Cost Component utilized to determine total hospital costs
85 allocated to the Medicaid program.

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93 paragraph (c) shall stand repealed on July 1, 2005.

94 (2) Outpatient hospital services. Where the same
95 services are reimbursed as clinic services, the division may
96 revise the rate or methodology of outpatient reimbursement to
97 maintain consistency, efficiency, economy and quality of care.

98 (3) Laboratory and x-ray services.

99 (4) Nursing facility services.

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

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

119 During the period between May 1, 2002, and December 1, 2002,

120 the Chairmen of the Public Health and Welfare Committees of the
121 Senate and the House of Representatives may appoint a joint study
122 committee to consider the issue of setting uniform reimbursement
123 rates for nursing facilities. The study committee will consist of
124 the Chairmen of the Public Health and Welfare Committees, three
125 (3) members of the Senate and three (3) members of the House. The
126 study committee shall complete its work in not more than three (3)
127 meetings.

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

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

154 (e) The division shall develop and implement, not
155 later than January 1, 2001, a case-mix payment add-on determined

156 by time studies and other valid statistical data that will
157 reimburse a nursing facility for the additional cost of caring for
158 a resident who has a diagnosis of Alzheimer's or other related
159 dementia and exhibits symptoms that require special care. Any
160 such case-mix add-on payment shall be supported by a determination
161 of additional cost. The division shall also develop and implement
162 as part of the fair rental reimbursement system for nursing
163 facility beds, an Alzheimer's resident bed depreciation enhanced
164 reimbursement system that will provide an incentive to encourage
165 nursing facilities to convert or construct beds for residents with
166 Alzheimer's or other related dementia.

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

190 (i) Advise the applicant or the applicant's
191 legal representative that a home- or other community-based setting

192 is appropriate;

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

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

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

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

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

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

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

223 (5) Periodic screening and diagnostic services for
224 individuals under age twenty-one (21) years as are needed to
225 identify physical and mental defects and to provide health care
226 treatment and other measures designed to correct or ameliorate
227 defects and physical and mental illness and conditions discovered

228 by the screening services regardless of whether these services are
229 included in the state plan. The division may include in its
230 periodic screening and diagnostic program those discretionary
231 services authorized under the federal regulations adopted to
232 implement Title XIX of the federal Social Security Act, as
233 amended. The division, in obtaining physical therapy services,
234 occupational therapy services, and services for individuals with
235 speech, hearing and language disorders, may enter into a
236 cooperative agreement with the State Department of Education for
237 the provision of those services to handicapped students by public
238 school districts using state funds that are provided from the
239 appropriation to the Department of Education to obtain federal
240 matching funds through the division. The division, in obtaining
241 medical and psychological evaluations for children in the custody
242 of the State Department of Human Services may enter into a
243 cooperative agreement with the State Department of Human Services
244 for the provision of those services using state funds that are
245 provided from the appropriation to the Department of Human
246 Services to obtain federal matching funds through the division.

247 * * *

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

262 (7) (a) Home health services for eligible persons, not
263 to exceed in cost the prevailing cost of nursing facility

264 services, not to exceed sixty (60) visits per year. All home
265 health visits must be precertified as required by the division.

266 (b) Repealed.

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

278 (9) (a) Legend and other drugs as may be determined by
279 the division. The division shall opt out of the federal drug
280 rebate program and shall create a closed drug formulary as soon as
281 practicable after the effective date of Senate Bill No. 2189, 2002
282 Regular Session. Drugs included on the formulary will be those
283 with the lowest and best price as determined through a bidding
284 process. The division may implement a program of prior approval
285 for drugs to the extent permitted by law. The division shall
286 allow seven (7) prescriptions per month for each
287 noninstitutionalized Medicaid recipient; however, after a
288 noninstitutionalized or institutionalized recipient has received
289 five (5) prescriptions in any month, each additional prescription
290 during that month must have the prior approval of the division.
291 The division shall not reimburse for any portion of a prescription
292 that exceeds a thirty-four-day supply of the drug based on the
293 daily dosage.

294 The dispensing fee for each new or refill prescription shall
295 be Three Dollars and Ninety-one Cents (\$3.91).

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

300 All claims for drugs for dually eligible Medicare/Medicaid
301 beneficiaries that are paid for by Medicare must be submitted to
302 Medicare for payment before they may be processed by the
303 division's on-line payment system.

304 The division shall develop a pharmacy policy in which drugs
305 in tamper-resistant packaging that are prescribed for a resident
306 of a nursing facility but are not dispensed to the resident shall
307 be returned to the pharmacy and not billed to Medicaid, in
308 accordance with guidelines of the State Board of Pharmacy.

309 (b) Legend and other drugs as may be determined by the
310 division. The division may implement a program of prior approval
311 for drugs to the extent permitted by law. Payment by the division
312 for covered multiple source drugs shall be limited to the lower of
313 the upper limits established and published by the Centers for
314 Medicare and Medicaid Services (CMS) plus a dispensing fee, or the
315 estimated acquisition cost (EAC) plus a dispensing fee, or the
316 providers' usual and customary charge to the general public. The
317 division shall allow seven (7) prescriptions per month for each
318 noninstitutionalized Medicaid recipient; however, after a
319 noninstitutionalized or institutionalized recipient has received
320 five (5) prescriptions in any month, each additional prescription
321 during that month must have the prior approval of the division.
322 The division shall not reimburse for any portion of a prescription
323 that exceeds a thirty-four-day supply of the drug based on the
324 daily dosage.

325 Payment for other covered drugs, other than multiple source
326 drugs with CMS upper limits, shall not exceed the lower of the
327 estimated acquisition cost plus a dispensing fee or the providers'
328 usual and customary charge to the general public.

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

334 The dispensing fee for each new or refill prescription shall
335 be Three Dollars and Ninety-one Cents (\$3.91).

336 The Medicaid provider shall not prescribe, the Medicaid
337 pharmacy shall not bill, and the division shall not reimburse for
338 name brand drugs if there are equally effective generic
339 equivalents available and if the generic equivalents are the least
340 expensive.

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

345 All claims for drugs for dually eligible Medicare/Medicaid
346 beneficiaries that are paid for by Medicare must be submitted to
347 Medicare for payment before they may be processed by the
348 division's on-line payment system.

349 The division shall develop a pharmacy policy in which drugs
350 in tamper-resistant packaging that are prescribed for a resident
351 of a nursing facility but are not dispensed to the resident shall
352 be returned to the pharmacy and not billed to Medicaid, in
353 accordance with guidelines of the State Board of Pharmacy.

354 As used in this paragraph (9), "estimated acquisition cost"
355 means twelve percent (12%) less than the average wholesale price
356 for a drug.

357 (c) The division may operate the drug program under the
358 provisions of subparagraph (b) until the closed drug formulary
359 required by subparagraph (a) is established and implemented.
360 Subparagraph (a) of this paragraph (9) shall stand repealed on
361 July 1, 2003.

362 (10) Dental care that is an adjunct to treatment of an
363 acute medical or surgical condition; services of oral surgeons and
364 dentists in connection with surgery related to the jaw or any
365 structure contiguous to the jaw or the reduction of any fracture
366 of the jaw or any facial bone; and emergency dental extractions
367 and treatment related thereto. On July 1, 1999, all fees for
368 dental care and surgery under authority of this paragraph (10)
369 shall be increased to one hundred sixty percent (160%) of the
370 amount of the reimbursement rate that was in effect on June 30,
371 1999. It is the intent of the Legislature to encourage more

372 dentists to participate in the Medicaid program.

373 (11) Eyeglasses for all Medicaid beneficiaries who have
374 (a) had * * * surgery on the eyeball or ocular muscle that results
375 in a vision change for which eyeglasses or a change in eyeglasses
376 is medically indicated within six (6) months of the surgery and is
377 in accordance with policies established by the division, or (b)
378 one (1) pair every five (5) years and in accordance with policies
379 established by the division. In either instance, the eyeglasses
380 must be prescribed by a physician skilled in diseases of the eye
381 or an optometrist, whichever the beneficiary may select.

382 (12) Intermediate care facility services.

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

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

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

397 (14) Clinic services. Such diagnostic, preventive,
398 therapeutic, rehabilitative or palliative services furnished to an
399 outpatient by or under the supervision of a physician or dentist
400 in a facility that is not a part of a hospital but that is
401 organized and operated to provide medical care to outpatients.
402 Clinic services shall include any services reimbursed as
403 outpatient hospital services that may be rendered in such a
404 facility, including those that become so after July 1, 1991. On
405 July 1, 1999, all fees for physicians' services reimbursed under
406 authority of this paragraph (14) shall be reimbursed at ninety
407 percent (90%) of the rate established on January 1, 1999, and as

408 adjusted each January thereafter, under Medicare (Title XVIII of
409 the Social Security Act, as amended), and which shall in no event
410 be less than seventy percent (70%) of the rate established on
411 January 1, 1994. All fees for physicians' services that are
412 covered by both Medicare and Medicaid shall be reimbursed at ten
413 percent (10%) of the adjusted Medicare payment established on
414 January 1, 1999, and as adjusted each January thereafter, under
415 Medicare (Title XVIII of the Social Security Act, as amended), and
416 which shall in no event be less than seventy percent (70%) of the
417 adjusted Medicare payment established on January 1, 1994. On July
418 1, 1999, all fees for dentists' services reimbursed under
419 authority of this paragraph (14) shall be increased to one hundred
420 sixty percent (160%) of the amount of the reimbursement rate that
421 was in effect on June 30, 1999.

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

438 (16) Mental health services. Approved therapeutic and
439 case management services (a) provided by * * * an approved
440 regional mental health/retardation center established under
441 Sections 41-19-31 through 41-19-39, or by another community mental
442 health service provider meeting the requirements of the Department
443 of Mental Health to be an approved mental health/retardation

444 center if determined necessary by the Department of Mental Health,
445 using state funds that are provided from the appropriation to the
446 State Department of Mental Health and/or funds transferred to the
447 department by a political subdivision or instrumentality of the
448 state and used to match federal funds under a cooperative
449 agreement between the division and the department, or (b) provided
450 by a facility that is certified by the State Department of Mental
451 Health to provide therapeutic and case management services, to be
452 reimbursed on a fee for service basis, or (c) provided in the
453 community by a facility or program operated by the Department of
454 Mental Health. Any such services provided by a facility described
455 in paragraph (b) must have the prior approval of the division to
456 be reimbursable under this section. After June 30, 1997, mental
457 health services provided by regional mental health/retardation
458 centers established under Sections 41-19-31 through 41-19-39, or
459 by hospitals as defined in Section 41-9-3(a) and/or their
460 subsidiaries and divisions, or by psychiatric residential
461 treatment facilities as defined in Section 43-11-1, or by another
462 community mental health service provider meeting the requirements
463 of the Department of Mental Health to be an approved mental
464 health/retardation center if determined necessary by the
465 Department of Mental Health, shall not be included in or provided
466 under any capitated managed care pilot program provided for under
467 paragraph (24) of this section.

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

474 (18) (a) Notwithstanding any other provision of this
475 section to the contrary, the division shall make additional
476 reimbursement to hospitals that serve a disproportionate share of
477 low-income patients and that meet the federal requirements for
478 those payments as provided in Section 1923 of the federal Social
479 Security Act and any applicable regulations. However, from and

480 after January 1, 1999, no public hospital shall participate in the
481 Medicaid disproportionate share program unless the public hospital
482 participates in an intergovernmental transfer program as provided
483 in Section 1903 of the federal Social Security Act and any
484 applicable regulations. Administration and support for
485 participating hospitals shall be provided by the Mississippi
486 Hospital Association.

487 (b) The division shall establish a Medicare Upper
488 Payment Limits Program, as defined in Section 1902(a)(30) of the
489 federal Social Security Act and any applicable federal
490 regulations, for hospitals, and may establish a Medicare Upper
491 Payments Limits Program for nursing facilities. The division
492 shall assess each hospital and, if the program is established for
493 nursing facilities, shall assess each nursing facility, for the
494 sole purpose of financing the state portion of the Medicare Upper
495 Payment Limits Program. This assessment shall be based on
496 Medicaid utilization, or other appropriate method consistent with
497 federal regulations, and will remain in effect as long as the
498 state participates in the Medicare Upper Payment Limits Program.
499 The division shall make additional reimbursement to hospitals and,
500 if the program is established for nursing facilities, shall make
501 additional reimbursement to nursing facilities, for the Medicare
502 Upper Payment Limits, as defined in Section 1902(a)(30) of the
503 federal Social Security Act and any applicable federal
504 regulations. This paragraph (b) shall stand repealed from and
505 after July 1, 2005.

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

511 (19) (a) Perinatal risk management services. The
512 division shall promulgate regulations to be effective from and
513 after October 1, 1988, to establish a comprehensive perinatal
514 system for risk assessment of all pregnant and infant Medicaid
515 recipients and for management, education and follow-up for those

516 who are determined to be at risk. Services to be performed
517 include case management, nutrition assessment/counseling,
518 psychosocial assessment/counseling and health education. The
519 division shall set reimbursement rates for providers in
520 conjunction with the State Department of Health.

521 (b) Early intervention system services. The
522 division shall cooperate with the State Department of Health,
523 acting as lead agency, in the development and implementation of a
524 statewide system of delivery of early intervention services, under
525 Part C of the Individuals with Disabilities Education Act (IDEA).

526 The State Department of Health shall certify annually in writing
527 to the executive director of the division the dollar amount of
528 state early intervention funds available that will be utilized as
529 a certified match for Medicaid matching funds. Those funds then
530 shall be used to provide expanded targeted case management
531 services for Medicaid eligible children with special needs who are
532 eligible for the state's early intervention system.

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

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

546 (21) Nurse practitioner services. Services furnished
547 by a registered nurse who is licensed and certified by the
548 Mississippi Board of Nursing as a nurse practitioner including,
549 but not limited to, nurse anesthetists, nurse midwives, family
550 nurse practitioners, family planning nurse practitioners,
551 pediatric nurse practitioners, obstetrics-gynecology nurse

552 practitioners and neonatal nurse practitioners, under regulations
553 adopted by the division. Reimbursement for those services shall
554 not exceed ninety percent (90%) of the reimbursement rate for
555 comparable services rendered by a physician.

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

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

573 (24) [Deleted]

574 (25) Birthing center services.

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

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

588 Services.

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

593 (29) The Division of Medicaid may apply for a waiver
594 from the Department of Health and Human Services for home- and
595 community-based services for developmentally disabled people using
596 state funds that are provided from the appropriation to the State
597 Department of Mental Health and/or funds transferred to the
598 department by a political subdivision or instrumentality of the
599 state and used to match federal funds under a cooperative
600 agreement between the division and the department, provided that
601 funds for these services are specifically appropriated to the
602 Department of Mental Health and/or transferred to the department
603 by a political subdivision or instrumentality of the state.

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

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

612 (32) Care and services provided in Christian Science
613 Sanatoria listed and certified by the Commission for Accreditation
614 of Christian Science Nursing Organizations/Facilities, Inc.,
615 rendered in connection with treatment by prayer or spiritual means
616 to the extent that those services are subject to reimbursement
617 under Section 1903 of the Social Security Act.

618 (33) Podiatrist services.

619 (34) The division shall make application to the United
620 States Health Care Financing Administration for a waiver to
621 develop a program of services to personal care and assisted living
622 homes in Mississippi. This waiver shall be completed by December
623 1, 1999.

624 (35) Services and activities authorized in Sections
625 43-27-101 and 43-27-103, using state funds that are provided from
626 the appropriation to the State Department of Human Services and
627 used to match federal funds under a cooperative agreement between
628 the division and the department.

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

636 (37) [Deleted]

637 (38) Chiropractic services: a chiropractor's manual
638 manipulation of the spine to correct a subluxation, if x-ray
639 demonstrates that a subluxation exists and if the subluxation has
640 resulted in a neuromusculoskeletal condition for which
641 manipulation is appropriate treatment, and related spinal x-rays
642 performed to document these conditions. Reimbursement for
643 chiropractic services shall not exceed Seven Hundred Dollars
644 (\$700.00) per year per beneficiary.

645 (39) Dually eligible Medicare/Medicaid beneficiaries.
646 The division shall pay the Medicare deductible and ten percent
647 (10%) coinsurance amounts for services available under Medicare
648 for the duration and scope of services otherwise available under
649 the Medicaid program.

650 (40) [Deleted]

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

660 department.

661 (42) Notwithstanding any other provision in this
662 article to the contrary, the division may develop a population
663 health management program for women and children health services
664 through the age of two (2) years. This program is primarily for
665 obstetrical care associated with low birth weight and pre-term
666 babies. The division may apply to the federal Centers for
667 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
668 any other waivers that may enhance the program. In order to
669 effect cost savings, the division may develop a revised payment
670 methodology that may include at-risk capitated payments, and may
671 require member participation in accordance with the terms and
672 conditions of an approved federal waiver.

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

678 (44) Nursing facility services for the severely
679 disabled.

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

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

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

694 (46) The division shall make application to the federal
695 Centers for Medicare and Medicaid Services (CMS) for a waiver to

696 develop and provide services for children with serious emotional
697 disturbances as defined in Section 43-14-1(1), which may include
698 home- and community-based services, case management services or
699 managed care services through mental health providers certified by
700 the Department of Mental Health. The division may implement and
701 provide services under this waived program only if funds for
702 these services are specifically appropriated for this purpose by
703 the Legislature, or if funds are voluntarily provided by affected
704 agencies.

705 (47) Notwithstanding any other provision in this
706 article to the contrary, the division, in conjunction with the
707 State Department of Health, shall develop and implement disease
708 management programs statewide for individuals with asthma,
709 diabetes or hypertension, including the use of grants, waivers,
710 demonstrations or other projects as necessary.

711 (48) Pediatric long-term acute care hospital services.

712 (a) Pediatric long-term acute care hospital
713 services means services provided to eligible persons under
714 twenty-one (21) years of age by a freestanding Medicare-certified
715 hospital that has an average length of inpatient stay greater than
716 twenty-five (25) days and that is primarily engaged in providing
717 chronic or long-term medical care to persons under twenty-one (21)
718 years of age.

719 (b) The services under this paragraph (48) shall
720 be reimbursed as a separate category of hospital services.

721 (49) The division shall establish copayments for all
722 Medicaid services for which copayments are allowable under federal
723 law or regulation, except for nonemergency transportation
724 services, and shall set the amount of the copayment for each of
725 those services at the maximum amount allowable under federal law
726 or regulation.

727 Notwithstanding any other provision of this article to the
728 contrary, the division shall reduce the rate of reimbursement to
729 providers for any service provided under this section by five
730 percent (5%) of the allowed amount for that service. However, the
731 reduction in the reimbursement rates required by this paragraph

732 shall not apply to inpatient hospital services, nursing facility
733 services, intermediate care facility services, psychiatric
734 residential treatment facility services, pharmacy services
735 provided under paragraph (9) of this section, or any service
736 provided by the University of Mississippi Medical Center or a
737 state agency, a state facility or a public agency that either
738 provides its own state match through intergovernmental transfer or
739 certification of funds to the division, or a service for which the
740 federal government sets the reimbursement methodology and rate.
741 In addition, the reduction in the reimbursement rates required by
742 this paragraph shall not apply to case management services and
743 home delivered meal services provided under the home- and
744 community-based services program for the elderly and disabled by a
745 planning and development district, if the planning and development
746 district transfers to the division a sum equal to the amount of
747 the reduction in reimbursement that would otherwise be made for
748 those services under this paragraph.

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

765 Notwithstanding any provision of this article, no new groups
766 or categories of recipients and new types of care and services may
767 be added without enabling legislation from the Mississippi

768 Legislature, except that the division may authorize those changes
769 without enabling legislation when the addition of recipients or
770 services is ordered by a court of proper authority. The executive
771 director shall keep the Governor advised on a timely basis of the
772 funds available for expenditure and the projected expenditures.
773 If current or projected expenditures of the division can be
774 reasonably anticipated to exceed the amounts appropriated for any
775 fiscal year, the Governor, after consultation with the executive
776 director, shall discontinue any or all of the payment of the types
777 of care and services as provided in this section that are deemed
778 to be optional services under Title XIX of the federal Social
779 Security Act, as amended, for any period necessary to not exceed
780 appropriated funds, and when necessary shall institute any other
781 cost containment measures on any program or programs authorized
782 under the article to the extent allowed under the federal law
783 governing that program or programs, it being the intent of the
784 Legislature that expenditures during any fiscal year shall not
785 exceed the amounts appropriated for that fiscal year.

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

797 This section shall stand repealed on July 1, 2004.

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

800 43-13-121. (1) The division shall administer the Medicaid
801 program * * * under the provisions of this article, and may do the
802 following:

803 (a) Adopt and promulgate reasonable rules, regulations

804 and standards, with approval of the Governor, and in accordance
805 with the Administrative Procedures Law, Section 25-43-1 et seq.:

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

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

812 (iii) Establishing reasonable fees, charges and
813 rates for medical services and drugs; * * * in doing so, the
814 division shall fix all of those fees, charges and rates at the
815 minimum levels absolutely necessary to provide the medical
816 assistance authorized by this article, and shall not change any of
817 those fees, charges or rates except as may be authorized in
818 Section 43-13-117;

819 (iv) Providing for fair and impartial hearings;

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

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

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

831 (c) Subject to the limits imposed by this article, to
832 submit a Medicaid plan * * * to the federal Department of Health
833 and Human Services for approval under the provisions of the Social
834 Security Act, to act for the state in making negotiations relative
835 to the submission and approval of that plan, to make such
836 arrangements, not inconsistent with the law, as may be required by
837 or under federal law to obtain and retain that approval and to
838 secure for the state the benefits of the provisions of that law.

839 No agreements, specifically including the general plan for

840 the operation of the Medicaid program in this state, shall be made
841 by and between the division and the Department of Health and Human
842 Services unless the Attorney General of the State of Mississippi
843 has reviewed the agreements, specifically including the
844 operational plan, and has certified in writing to the Governor and
845 to the executive director of the division that the agreements,
846 including the plan of operation, have been drawn strictly in
847 accordance with the terms and requirements of this article;

848 (d) In accordance with the purposes and intent of this
849 article and in compliance with its provisions, provide for aged
850 persons otherwise eligible for the benefits provided under Title
851 XVIII of the federal Social Security Act by expenditure of funds
852 available for those purposes;

853 (e) To make reports to the federal Department of Health
854 and Human Services as from time to time may be required by that
855 federal department and to the Mississippi Legislature as * * *
856 provided in this section;

857 (f) Define and determine the scope, duration and amount
858 of Medicaid that may be provided in accordance with this article
859 and establish priorities therefor in conformity with this article;

860 (g) Cooperate and contract with other state agencies
861 for the purpose of coordinating Medicaid provided under this
862 article and eliminating duplication and inefficiency in the
863 Medicaid program;

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

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

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

871 (k) To recover any and all payments by the division or
872 by the Medicaid Commission fraudulently obtained by a recipient or
873 provider. Additionally, if recovery of any payments fraudulently
874 obtained by a recipient or provider is made in any court, then,
875 upon motion of the Governor, the judge of the court may award

876 twice the payments recovered as damages;

877 (1) Have full, complete and plenary power and authority
878 to conduct such investigations as it may deem necessary and
879 requisite of alleged or suspected violations or abuses of the
880 provisions of this article or of the regulations adopted under
881 this article including, but not limited to, fraudulent or unlawful
882 act or deed by applicants for Medicaid or other benefits, or
883 payments made to any person, firm or corporation under the terms,
884 conditions and authority of this article, to suspend or disqualify
885 any provider of services, applicant or recipient for gross abuse,
886 fraudulent or unlawful acts for such periods, including
887 permanently, and under such conditions as the division * * * deems
888 proper and just, including the imposition of a legal rate of
889 interest on the amount improperly or incorrectly paid. Recipients
890 who are found to have misused or abused Medicaid benefits may be
891 locked into one (1) physician and/or one (1) pharmacy of the
892 recipient's choice for a reasonable amount of time in order to
893 educate and promote appropriate use of medical services, in
894 accordance with federal regulations. If an administrative hearing
895 becomes necessary, the division may, if the provider does not
896 succeed in his defense, tax the costs of the administrative
897 hearing, including the costs of the court reporter or stenographer
898 and transcript, to the provider. The convictions of a recipient
899 or a provider in a state or federal court for abuse, fraudulent or
900 unlawful acts under this chapter shall constitute an automatic
901 disqualification of the recipient or automatic disqualification of
902 the provider from participation under the Medicaid program.

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

910 (m) Establish and provide such methods of
911 administration as may be necessary for the proper and efficient

912 operation of the Medicaid program, fully utilizing computer
913 equipment as may be necessary to oversee and control all current
914 expenditures for purposes of this article, and to closely monitor
915 and supervise all recipient payments and vendors rendering * * *
916 services under this article;

917 (n) To cooperate and contract with the federal
918 government for the purpose of providing Medicaid to Vietnamese and
919 Cambodian refugees, under the provisions of Public Law 94-23 and
920 Public Law 94-24, including any amendments to those laws, only to
921 the extent that the Medicaid assistance and the administrative
922 cost related thereto are one hundred percent (100%) reimbursable
923 by the federal government. For the purposes of Section 43-13-117,
924 persons receiving Medicaid under Public Law 94-23 and Public Law
925 94-24, including any amendments to those laws, shall not be
926 considered a new group or category of recipient; and

927 (o) The division shall impose penalties upon Medicaid
928 only, Title XIX participating long-term care facilities found to
929 be in noncompliance with division and certification standards in
930 accordance with federal and state regulations, including interest
931 at the same rate calculated by the Department of Health and Human
932 Services and/or the Centers for Medicare and Medicaid Services
933 (CMS) under federal regulations.

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

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

944 (4) The division and its hearing officers shall have power
945 to preserve and enforce order during hearings; to issue subpoenas
946 for, to administer oaths to and to compel the attendance and
947 testimony of witnesses, or the production of books, papers,

948 documents and other evidence, or the taking of depositions before
949 any designated individual competent to administer oaths; to
950 examine witnesses; and to do all things conformable to law that
951 may be necessary to enable them effectively to discharge the
952 duties of their office. In compelling the attendance and
953 testimony of witnesses, or the production of books, papers,
954 documents and other evidence, or the taking of depositions, as
955 authorized by this section, the division or its hearing officers
956 may designate an individual employed by the division or some other
957 suitable person to execute and return that process, whose action
958 in executing and returning that process shall be as lawful as if
959 done by the sheriff or some other proper officer authorized to
960 execute and return process in the county where the witness may
961 reside. In carrying out the investigatory powers under the
962 provisions of this article, the executive director or other
963 designated person or persons may examine, obtain, copy or
964 reproduce the books, papers, documents, medical charts,
965 prescriptions and other records relating to medical care and
966 services furnished by the provider to a recipient or designated
967 recipients of Medicaid services under investigation. In the
968 absence of the voluntary submission of the books, papers,
969 documents, medical charts, prescriptions and other records, the
970 Governor, the executive director, or other designated person may
971 issue and serve subpoenas instantly upon the provider, his agent,
972 servant or employee for the production of the books, papers,
973 documents, medical charts, prescriptions or other records during
974 an audit or investigation of the provider. If any provider or his
975 agent, servant or employee * * * refuses to produce the records
976 after being duly subpoenaed, the executive director may certify
977 those facts and institute contempt proceedings in the manner,
978 time, and place as authorized by law for administrative
979 proceedings. As an additional remedy, the division may recover
980 all amounts paid to the provider covering the period of the audit
981 or investigation, inclusive of a legal rate of interest and a
982 reasonable attorney's fee and costs of court if suit becomes
983 necessary. Division staff shall have immediate access to the

984 provider's physical location, facilities, records, documents,
985 books, and any other records relating to medical care and services
986 rendered to recipients during regular business hours.

987 (5) If any person in proceedings before the division
988 disobeys or resists any lawful order or process, or misbehaves
989 during a hearing or so near the place thereof as to obstruct the
990 same, or neglects to produce, after having been ordered to do so,
991 any pertinent book, paper or document, or refuses to appear after
992 having been subpoenaed, or upon appearing refuses to take the oath
993 as a witness, or after having taken the oath refuses to be
994 examined according to law, the executive director shall certify
995 the facts to any court having jurisdiction in the place in which
996 it is sitting, and the court shall thereupon, in a summary manner,
997 hear the evidence as to the acts complained of, and if the
998 evidence so warrants, punish that person in the same manner and to
999 the same extent as for a contempt committed before the court, or
1000 commit that person upon the same condition as if the doing of the
1001 forbidden act had occurred with reference to the process of, or in
1002 the presence of, the court.

1003 (6) In suspending or terminating any provider from
1004 participation in the Medicaid program, the division shall preclude
1005 the provider from submitting claims for payment, either personally
1006 or through any clinic, group, corporation or other association to
1007 the division or its fiscal agents for any services or supplies
1008 provided under the Medicaid program except for those services or
1009 supplies provided before the suspension or termination. No
1010 clinic, group, corporation or other association that is a provider
1011 of services shall submit claims for payment to the division or its
1012 fiscal agents for any services or supplies provided by a person
1013 within that organization who has been suspended or terminated from
1014 participation in the Medicaid program except for those services or
1015 supplies provided before the suspension or termination. When this
1016 provision is violated by a provider of services that is a clinic,
1017 group, corporation or other association, the division may suspend
1018 or terminate that organization from participation. Suspension may
1019 be applied by the division to all known affiliates of a provider,

1020 provided that each decision to include an affiliate is made on a
1021 case-by-case basis after giving due regard to all relevant facts
1022 and circumstances. The violation, failure, or inadequacy of
1023 performance may be imputed to a person with whom the provider is
1024 affiliated where that conduct was accomplished within the course
1025 of his official duty or was effectuated by him with the knowledge
1026 or approval of that person.

1027 (7) The division may deny or revoke enrollment in the
1028 Medicaid program to a provider if any of the following are found
1029 to be applicable to the provider, his agent, a managing employee,
1030 or any person having an ownership interest equal to five percent
1031 (5%) or greater in the provider:

1032 (a) Failure to truthfully or fully disclose any and all
1033 information required, or the concealment of any and all
1034 information required, on a claim, a provider application or a
1035 provider agreement, or the making of a false or misleading
1036 statement to the division relative to the Medicaid program.

1037 (b) Previous or current exclusion, suspension,
1038 termination from or the involuntary withdrawing from participation
1039 in the Medicaid program, any other state's Medicaid program,
1040 Medicare or any other public or private health or health insurance
1041 program. If the division ascertains that a provider has been
1042 convicted of a felony under federal or state law for an offense
1043 that the division determines is detrimental to the best interest
1044 of the program or of Medicaid beneficiaries, the division may
1045 refuse to enter into an agreement with that provider, or may
1046 terminate or refuse to renew an existing agreement.

1047 (c) Conviction under federal or state law of a criminal
1048 offense relating to the delivery of any goods, services or
1049 supplies, including the performance of management or
1050 administrative services relating to the delivery of the goods,
1051 services or supplies, under the Medicaid program, any other
1052 state's Medicaid program, Medicare or any other public or private
1053 health or health insurance program.

1054 (d) Conviction under federal or state law of a criminal
1055 offense relating to the neglect or abuse of a patient in

1056 connection with the delivery of any goods, services or supplies.

1057 (e) Conviction under federal or state law of a criminal
1058 offense relating to the unlawful manufacture, distribution,
1059 prescription, or dispensing of a controlled substance.

1060 (f) Conviction under federal or state law of a criminal
1061 offense relating to fraud, theft, embezzlement, breach of
1062 fiduciary responsibility or other financial misconduct.

1063 (g) Conviction under federal or state law of a criminal
1064 offense punishable by imprisonment of a year or more that involves
1065 moral turpitude, or acts against the elderly, children or infirm.

1066 (h) Conviction under federal or state law of a criminal
1067 offense in connection with the interference or obstruction of any
1068 investigation into any criminal offense listed in paragraphs (c)
1069 through (i) of this subsection.

1070 (i) Sanction for a violation of federal or state laws
1071 or rules relative to the Medicaid program, any other state's
1072 Medicaid program, Medicare or any other public health care or
1073 health insurance program.

1074 (j) Revocation of license or certification.

1075 (k) Failure to pay recovery properly assessed or
1076 pursuant to an approved repayment schedule under the Medicaid
1077 program.

1078 (l) Failure to meet any condition of enrollment.

1079 **SECTION 3.** Section 43-13-123, Mississippi Code of 1972, is
1080 amended as follows:

1081 43-13-123. The determination of the method of providing
1082 payment of claims under this article shall be made by the
1083 division, with approval of the Governor, which methods may be:

1084 (a) By contract with insurance companies licensed to do
1085 business in the State of Mississippi or with nonprofit hospital
1086 service corporations, medical or dental service corporations,
1087 authorized to do business in Mississippi to underwrite on an
1088 insured premium approach, such medical assistance benefits as may
1089 be available, and any carrier selected under the provisions of
1090 this article is * * * expressly authorized and empowered to
1091 undertake the performance of the requirements of that contract.

1092 (b) By contract with an insurance company licensed to
1093 do business in the State of Mississippi or with nonprofit hospital
1094 service, medical or dental service organizations, or other
1095 organizations including data processing companies, authorized to
1096 do business in Mississippi to act as fiscal agent.

1097 The division shall obtain services to be provided under
1098 either of the above-described provisions in accordance with the
1099 Personal Service Contract Review Board Procurement
1100 Regulations. * * *

1101 The authorization of the foregoing methods shall not preclude
1102 other methods of providing payment of claims through direct
1103 operation of the program by the state or its agencies.

1104 **SECTION 4.** Section 43-13-127, Mississippi Code of 1972, is
1105 amended as follows:

1106 43-13-127. (1) Within sixty (60) days after the end of each
1107 fiscal year and at each regular session of the Legislature, the
1108 division shall make and publish a report to the Governor and to
1109 the Legislature, showing for the period of time covered the
1110 following:

1111 (a) The total number of recipients;

1112 (b) The total amount paid for medical assistance and
1113 care under this article;

1114 (c) The total number of applications;

1115 (d) The number of applications approved;

1116 (e) The number of applications denied;

1117 (f) The amount expended for administration of the
1118 provisions of this article;

1119 (g) The amount of money received from the federal
1120 government, if any;

1121 (h) The amount of money recovered by reason of
1122 collections from third persons by reason of assignment or
1123 subrogation, and the disposition of the same;

1124 (i) The actions and activities of the division in
1125 detecting and investigating suspected or alleged fraudulent
1126 practices, violations and abuses of the program; and

1127 (j) Any recommendations it may have as to expanding,

1128 enlarging, limiting or restricting, the eligibility of persons
1129 covered by this article or services provided by this article, to
1130 make more effective the basic purposes of this article; to
1131 eliminate or curtail fraudulent practices and inequities in the
1132 plan or administration thereof; and to continue to participate in
1133 receiving federal funds for the furnishing of medical assistance
1134 under Title XIX of the Social Security Act or other federal law.

1135 (2) In addition to the reports required by subsection (1) of
1136 this section, the division shall submit a report each month to the
1137 Chairmen of the Public Health and Welfare Committees of the Senate
1138 and the House of Representatives and to the Joint Legislative
1139 Budget Committee that contains the information specified in each
1140 paragraph of subsection (1) for the preceding month.

1141 **SECTION 5.** Section 43-13-145, Mississippi Code of 1972, is
1142 amended as follows:

1143 **[Through June 30, 2002, subsection (1) of this section shall**
1144 **read as follows:]**

1145 43-13-145. (1) Upon each nursing facility * * * and each
1146 intermediate care facility for the mentally retarded licensed by
1147 the State of Mississippi, there is levied an assessment in the
1148 amount of Two Dollars (\$2.00) per day * * * for each * * *
1149 licensed and/or certified bed of the facility. The division may
1150 apply for a waiver from the United States Secretary of Health and
1151 Human Services to exempt nonprofit, public, charitable or
1152 religious facilities from the assessment levied under this
1153 subsection, and if a waiver is granted, those facilities shall be
1154 exempt from any assessment levied under this subsection after the
1155 date that the division receives notice that the waiver has been
1156 granted.

1157 **[From and after July 1, 2002, subsection (1) of this section**
1158 **shall read as follows:]**

1159 43-13-145. (1) (a) Upon each nursing facility and each
1160 intermediate care facility for the mentally retarded licensed by
1161 the State of Mississippi, there is levied an assessment in the
1162 amount of Three Dollars (\$3.00) per day for each licensed and/or
1163 certified bed of the facility. The division may apply for a

1164 waiver from the United States Secretary of Health and Human
1165 Services to exempt nonprofit, public, charitable or religious
1166 facilities from the assessment levied under this subsection, and
1167 if a waiver is granted, those facilities shall be exempt from any
1168 assessment levied under this subsection after the date that the
1169 division receives notice that the waiver has been granted.

1170 (b) A nursing facility or intermediate care facility
1171 for the mentally retarded is exempt from the assessment levied
1172 under this subsection if the facility is operated under the
1173 direction and control of:

1174 (i) The United States Veterans Administration or
1175 other agency or department of the United States government;

1176 (ii) The State Veterans Affairs Board;

1177 (iii) The University of Mississippi Medical
1178 Center; or

1179 (iv) A state agency or a state facility that
1180 either provides its own state match through intergovernmental
1181 transfer or certification of funds to the division.

1182 (2) (a) Upon each psychiatric residential treatment
1183 facility licensed by the State of Mississippi, there is levied an
1184 assessment in the amount of Three Dollars (\$3.00) per day for each
1185 licensed and/or certified bed of the facility.

1186 (b) A psychiatric residential treatment facility is
1187 exempt from the assessment levied under this subsection if the
1188 facility is operated under the direction and control of:

1189 (i) The United States Veterans Administration or
1190 other agency or department of the United States government;

1191 (ii) The University of Mississippi Medical Center;

1192 (iii) A state agency or a state facility that
1193 either provides its own state match through intergovernmental
1194 transfer or certification of funds to the division.

1195 (3) (a) Upon each hospital licensed by the State of
1196 Mississippi, there is levied an assessment in the amount of One
1197 Dollar and Fifty Cents (\$1.50) per day for each licensed inpatient
1198 acute care bed of the hospital.

1199 (b) A hospital is exempt from the assessment levied

1200 under this subsection if the hospital is operated under the
1201 direction and control of:

1202 (i) The United States Veterans Administration or
1203 other agency or department of the United States government;

1204 (ii) The University of Mississippi Medical Center;
1205 or

1206 (iii) A state agency or a state facility that
1207 either provides its own state match through intergovernmental
1208 transfer or certification of funds to the division.

1209 (4) Each health care facility that is subject to the
1210 provisions of this section shall keep and preserve such suitable
1211 books and records as may be necessary to determine the amount of
1212 assessment for which it is liable under this section. The books
1213 and records shall be kept and preserved for a period of not less
1214 than five (5) years, and those books and records shall be open for
1215 examination during business hours by the division, the State Tax
1216 Commission, the Office of the Attorney General, and the State
1217 Department of Health.

1218 (5) The assessment levied under this section shall be
1219 collected by the division each month beginning on the effective
1220 date of Senate Bill No. 2189, 2002 Regular Session.

1221 (6) All assessments collected under this section shall be
1222 deposited in the Medical Care Fund created by Section 43-13-143.

1223 (7) The assessment levied under this section shall be in
1224 addition to any other assessments, taxes or fees levied by law,
1225 and the assessment shall constitute a debt due the State of
1226 Mississippi from the time the assessment is due until it is paid.

1227 (8) (a) If a health care facility that is liable for
1228 payment of the assessment levied under this section does not pay
1229 the assessment when it is due, the division shall give written
1230 notice to the health care facility by certified or registered mail
1231 demanding payment of the assessment within ten (10) days from the
1232 date of delivery of the notice. * * * If the health care facility
1233 fails or refuses to pay the assessment after receiving the notice
1234 and demand from the division, the division shall withhold from any
1235 Medicaid reimbursement payments that are due to the health care

1236 facility the amount of the unpaid assessment and a penalty of ten
1237 percent (10%) of the amount of the assessment, plus the legal rate
1238 of interest until the assessment is paid in full. If the health
1239 care facility does not participate in the Medicaid program, the
1240 division shall turn over to the Office of the Attorney General the
1241 collection of the unpaid assessment by civil action. In any such
1242 civil action, the Office of the Attorney General shall collect the
1243 amount of the unpaid assessment and a penalty of ten percent (10%)
1244 of the amount of the assessment, plus the legal rate of interest
1245 until the assessment is paid in full.

1246 (b) As an additional or alternative method for
1247 collecting unpaid assessments under this section, if a health care
1248 facility fails or refuses to pay the assessment after receiving
1249 notice and demand from the division, the division may file a
1250 notice of a tax lien with the circuit clerk of the county in which
1251 the health care facility is located, for the amount of the unpaid
1252 assessment and a penalty of ten percent (10%) of the amount of the
1253 assessment, plus the legal rate of interest until the assessment
1254 is paid in full. Immediately upon receipt of notice of the tax
1255 lien for the assessment, the circuit clerk shall enter the notice
1256 of the tax lien as a judgment upon the judgment roll and show in
1257 the appropriate columns the name of the health care facility as
1258 judgment debtor, the name of the division as judgment creditor,
1259 the amount of the unpaid assessment, and the date and time or
1260 enrollment. The judgment shall be valid as against mortgagees,
1261 pledgees, entrusters, purchasers, judgment creditors and other
1262 persons from the time of filing with the clerk. The amount of the
1263 judgment shall be a debt due the State of Mississippi and remain a
1264 lien upon the tangible property of the health care facility until
1265 the judgment is satisfied. The judgment shall be the equivalent
1266 of any enrolled judgment of a court of record and shall serve as
1267 authority for the issuance of writs of execution, writs of
1268 attachment or other remedial writs.

1269 **SECTION 6.** Section 41-7-191, Mississippi Code of 1972, is
1270 amended as follows:

1271 41-7-191. (1) No person shall engage in any of the

1272 following activities without obtaining the required certificate of
1273 need:

1274 (a) The construction, development or other
1275 establishment of a new health care facility;

1276 (b) The relocation of a health care facility or portion
1277 thereof, or major medical equipment, unless such relocation of a
1278 health care facility or portion thereof, or major medical
1279 equipment, which does not involve a capital expenditure by or on
1280 behalf of a health care facility, is within five thousand two
1281 hundred eighty (5,280) feet from the main entrance of the health
1282 care facility;

1283 (c) Any change * * * in the existing bed complement of
1284 any health care facility through the addition or conversion of any
1285 beds or the alteration, modernizing or refurbishing of any unit or
1286 department in which the beds may be located; * * *

1287 (d) Offering of the following health services if those
1288 services have not been provided on a regular basis by the proposed
1289 provider of such services within the period of twelve (12) months
1290 prior to the time such services would be offered:

1291 (i) Open heart surgery services;

1292 (ii) Cardiac catheterization services;

1293 (iii) Comprehensive inpatient rehabilitation
1294 services;

1295 (iv) Licensed psychiatric services;

1296 (v) Licensed chemical dependency services;

1297 (vi) Radiation therapy services;

1298 (vii) Diagnostic imaging services of an invasive
1299 nature, i.e. invasive digital angiography;

1300 (viii) Nursing home care as defined in
1301 subparagraphs (iv), (vi) and (viii) of Section 41-7-173(h);

1302 (ix) Home health services;

1303 (x) Swing-bed services;

1304 (xi) Ambulatory surgical services;

1305 (xii) Magnetic resonance imaging services;

1306 (xiii) Extracorporeal shock wave lithotripsy
1307 services;

1308 (xiv) Long-term care hospital services;

1309 (xv) Positron Emission Tomography (PET) services;

1310 (e) The relocation of one or more health services from
1311 one physical facility or site to another physical facility or
1312 site, unless such relocation, which does not involve a capital
1313 expenditure by or on behalf of a health care facility, (i) is to a
1314 physical facility or site within one thousand three hundred twenty
1315 (1,320) feet from the main entrance of the health care facility
1316 where the health care service is located, or (ii) is the result of
1317 an order of a court of appropriate jurisdiction or a result of
1318 pending litigation in such court, or by order of the State
1319 Department of Health, or by order of any other agency or legal
1320 entity of the state, the federal government, or any political
1321 subdivision of either, whose order is also approved by the State
1322 Department of Health;

1323 (f) The acquisition or otherwise control of any major
1324 medical equipment for the provision of medical services; provided,
1325 however, (i) the acquisition of any major medical equipment used
1326 only for research purposes, and (ii) the acquisition of major
1327 medical equipment to replace medical equipment for which a
1328 facility is already providing medical services and for which the
1329 State Department of Health has been notified before the date of
1330 such acquisition shall be exempt from this paragraph; an
1331 acquisition for less than fair market value must be reviewed, if
1332 the acquisition at fair market value would be subject to review;

1333 (g) Changes of ownership of existing health care
1334 facilities in which a notice of intent is not filed with the State
1335 Department of Health at least thirty (30) days prior to the date
1336 such change of ownership occurs, or a change in services or bed
1337 capacity as prescribed in paragraph (c) or (d) of this subsection
1338 as a result of the change of ownership; an acquisition for less
1339 than fair market value must be reviewed, if the acquisition at
1340 fair market value would be subject to review;

1341 (h) The change of ownership of any health care facility
1342 defined in subparagraphs (iv), (vi) and (viii) of Section
1343 41-7-173(h), in which a notice of intent as described in paragraph

1344 (g) has not been filed and if the Executive Director, Division of
1345 Medicaid, Office of the Governor, has not certified in writing
1346 that there will be no increase in allowable costs to Medicaid from
1347 revaluation of the assets or from increased interest and
1348 depreciation as a result of the proposed change of ownership;

1349 (i) Any activity described in paragraphs (a) through
1350 (h) if undertaken by any person if that same activity would
1351 require certificate of need approval if undertaken by a health
1352 care facility;

1353 (j) Any capital expenditure or deferred capital
1354 expenditure by or on behalf of a health care facility not covered
1355 by paragraphs (a) through (h);

1356 (k) The contracting of a health care facility as
1357 defined in subparagraphs (i) through (viii) of Section 41-7-173(h)
1358 to establish a home office, subunit, or branch office in the space
1359 operated as a health care facility through a formal arrangement
1360 with an existing health care facility as defined in subparagraph
1361 (ix) of Section 41-7-173(h).

1362 (2) The State Department of Health shall not grant approval
1363 for or issue a certificate of need to any person proposing the new
1364 construction of, addition to, or expansion of any health care
1365 facility defined in subparagraphs (iv) (skilled nursing facility)
1366 and (vi) (intermediate care facility) of Section 41-7-173(h) or
1367 the conversion of vacant hospital beds to provide skilled or
1368 intermediate nursing home care, except as hereinafter authorized:

1369 (a) The department may issue a certificate of need to
1370 any person proposing the new construction of any health care
1371 facility defined in subparagraphs (iv) and (vi) of Section
1372 41-7-173(h) as part of a life care retirement facility, in any
1373 county bordering on the Gulf of Mexico in which is located a
1374 National Aeronautics and Space Administration facility, not to
1375 exceed forty (40) beds. From and after July 1, 1999, there shall
1376 be no prohibition or restrictions on participation in the Medicaid
1377 program (Section 43-13-101 et seq.) for the beds in the health
1378 care facility that were authorized under this paragraph (a).

1379 (b) The department may issue certificates of need in

1380 Harrison County to provide skilled nursing home care for
1381 Alzheimer's Disease patients and other patients, not to exceed one
1382 hundred fifty (150) beds. From and after July 1, 1999, there
1383 shall be no prohibition or restrictions on participation in the
1384 Medicaid program (Section 43-13-101 et seq.) for the beds in the
1385 nursing facilities that were authorized under this paragraph (b).

1386 (c) The department may issue a certificate of need for
1387 the addition to or expansion of any skilled nursing facility that
1388 is part of an existing continuing care retirement community
1389 located in Madison County, provided that the recipient of the
1390 certificate of need agrees in writing that the skilled nursing
1391 facility will not at any time participate in the Medicaid program
1392 (Section 43-13-101 et seq.) or admit or keep any patients in the
1393 skilled nursing facility who are participating in the Medicaid
1394 program. This written agreement by the recipient of the
1395 certificate of need shall be fully binding on any subsequent owner
1396 of the skilled nursing facility, if the ownership of the facility
1397 is transferred at any time after the issuance of the certificate
1398 of need. Agreement that the skilled nursing facility will not
1399 participate in the Medicaid program shall be a condition of the
1400 issuance of a certificate of need to any person under this
1401 paragraph (c), and if such skilled nursing facility at any time
1402 after the issuance of the certificate of need, regardless of the
1403 ownership of the facility, participates in the Medicaid program or
1404 admits or keeps any patients in the facility who are participating
1405 in the Medicaid program, the State Department of Health shall
1406 revoke the certificate of need, if it is still outstanding, and
1407 shall deny or revoke the license of the skilled nursing facility,
1408 at the time that the department determines, after a hearing
1409 complying with due process, that the facility has failed to comply
1410 with any of the conditions upon which the certificate of need was
1411 issued, as provided in this paragraph and in the written agreement
1412 by the recipient of the certificate of need. The total number of
1413 beds that may be authorized under the authority of this paragraph
1414 (c) shall not exceed sixty (60) beds.

1415 (d) The State Department of Health may issue a

1416 certificate of need to any hospital located in DeSoto County for
1417 the new construction of a skilled nursing facility, not to exceed
1418 one hundred twenty (120) beds, in DeSoto County. From and after
1419 July 1, 1999, there shall be no prohibition or restrictions on
1420 participation in the Medicaid program (Section 43-13-101 et seq.)
1421 for the beds in the nursing facility that were authorized under
1422 this paragraph (d).

1423 (e) The State Department of Health may issue a
1424 certificate of need for the construction of a nursing facility or
1425 the conversion of beds to nursing facility beds at a personal care
1426 facility for the elderly in Lowndes County that is owned and
1427 operated by a Mississippi nonprofit corporation, not to exceed
1428 sixty (60) beds. From and after July 1, 1999, there shall be no
1429 prohibition or restrictions on participation in the Medicaid
1430 program (Section 43-13-101 et seq.) for the beds in the nursing
1431 facility that were authorized under this paragraph (e).

1432 (f) The State Department of Health may issue a
1433 certificate of need for conversion of a county hospital facility
1434 in Itawamba County to a nursing facility, not to exceed sixty (60)
1435 beds, including any necessary construction, renovation or
1436 expansion. From and after July 1, 1999, there shall be no
1437 prohibition or restrictions on participation in the Medicaid
1438 program (Section 43-13-101 et seq.) for the beds in the nursing
1439 facility that were authorized under this paragraph (f).

1440 (g) The State Department of Health may issue a
1441 certificate of need for the construction or expansion of nursing
1442 facility beds or the conversion of other beds to nursing facility
1443 beds in either Hinds, Madison or Rankin Counties, not to exceed
1444 sixty (60) beds. From and after July 1, 1999, there shall be no
1445 prohibition or restrictions on participation in the Medicaid
1446 program (Section 43-13-101 et seq.) for the beds in the nursing
1447 facility that were authorized under this paragraph (g).

1448 (h) The State Department of Health may issue a
1449 certificate of need for the construction or expansion of nursing
1450 facility beds or the conversion of other beds to nursing facility
1451 beds in either Hancock, Harrison or Jackson Counties, not to

1452 exceed sixty (60) beds. From and after July 1, 1999, there shall
1453 be no prohibition or restrictions on participation in the Medicaid
1454 program (Section 43-13-101 et seq.) for the beds in the facility
1455 that were authorized under this paragraph (h).

1456 (i) The department may issue a certificate of need for
1457 the new construction of a skilled nursing facility in Leake
1458 County, provided that the recipient of the certificate of need
1459 agrees in writing that the skilled nursing facility will not at
1460 any time participate in the Medicaid program (Section 43-13-101 et
1461 seq.) or admit or keep any patients in the skilled nursing
1462 facility who are participating in the Medicaid program. This
1463 written agreement by the recipient of the certificate of need
1464 shall be fully binding on any subsequent owner of the skilled
1465 nursing facility, if the ownership of the facility is transferred
1466 at any time after the issuance of the certificate of need.
1467 Agreement that the skilled nursing facility will not participate
1468 in the Medicaid program shall be a condition of the issuance of a
1469 certificate of need to any person under this paragraph (i), and if
1470 such skilled nursing facility at any time after the issuance of
1471 the certificate of need, regardless of the ownership of the
1472 facility, participates in the Medicaid program or admits or keeps
1473 any patients in the facility who are participating in the Medicaid
1474 program, the State Department of Health shall revoke the
1475 certificate of need, if it is still outstanding, and shall deny or
1476 revoke the license of the skilled nursing facility, at the time
1477 that the department determines, after a hearing complying with due
1478 process, that the facility has failed to comply with any of the
1479 conditions upon which the certificate of need was issued, as
1480 provided in this paragraph and in the written agreement by the
1481 recipient of the certificate of need. The provision of Section
1482 43-7-193(1) regarding substantial compliance of the projection of
1483 need as reported in the current State Health Plan is waived for
1484 the purposes of this paragraph. The total number of nursing
1485 facility beds that may be authorized by any certificate of need
1486 issued under this paragraph (i) shall not exceed sixty (60) beds.
1487 If the skilled nursing facility authorized by the certificate of

1488 need issued under this paragraph is not constructed and fully
1489 operational within eighteen (18) months after July 1, 1994, the
1490 State Department of Health, after a hearing complying with due
1491 process, shall revoke the certificate of need, if it is still
1492 outstanding, and shall not issue a license for the skilled nursing
1493 facility at any time after the expiration of the eighteen-month
1494 period.

1495 (j) The department may issue certificates of need to
1496 allow any existing freestanding long-term care facility in
1497 Tishomingo County and Hancock County that on July 1, 1995, is
1498 licensed with fewer than sixty (60) beds. For the purposes of
1499 this paragraph (j), the provision of Section 41-7-193(1) requiring
1500 substantial compliance with the projection of need as reported in
1501 the current State Health Plan is waived. From and after July 1,
1502 1999, there shall be no prohibition or restrictions on
1503 participation in the Medicaid program (Section 43-13-101 et seq.)
1504 for the beds in the long-term care facilities that were authorized
1505 under this paragraph (j).

1506 (k) The department may issue a certificate of need for
1507 the construction of a nursing facility at a continuing care
1508 retirement community in Lowndes County. The total number of beds
1509 that may be authorized under the authority of this paragraph (k)
1510 shall not exceed sixty (60) beds. From and after July 1, 2001,
1511 the prohibition on the facility participating in the Medicaid
1512 program (Section 43-13-101 et seq.) that was a condition of
1513 issuance of the certificate of need under this paragraph (k) shall
1514 be revised as follows: The nursing facility may participate in
1515 the Medicaid program from and after July 1, 2001, if the owner of
1516 the facility on July 1, 2001, agrees in writing that no more than
1517 thirty (30) of the beds at the facility will be certified for
1518 participation in the Medicaid program, and that no claim will be
1519 submitted for Medicaid reimbursement for more than thirty (30)
1520 patients in the facility in any month or for any patient in the
1521 facility who is in a bed that is not Medicaid-certified. This
1522 written agreement by the owner of the facility shall be a
1523 condition of licensure of the facility, and the agreement shall be

1524 fully binding on any subsequent owner of the facility if the
1525 ownership of the facility is transferred at any time after July 1,
1526 2001. After this written agreement is executed, the Division of
1527 Medicaid and the State Department of Health shall not certify more
1528 than thirty (30) of the beds in the facility for participation in
1529 the Medicaid program. If the facility violates the terms of the
1530 written agreement by admitting or keeping in the facility on a
1531 regular or continuing basis more than thirty (30) patients who are
1532 participating in the Medicaid program, the State Department of
1533 Health shall revoke the license of the facility, at the time that
1534 the department determines, after a hearing complying with due
1535 process, that the facility has violated the written agreement.

1536 (l) Provided that funds are specifically appropriated
1537 therefor by the Legislature, the department may issue a
1538 certificate of need to a rehabilitation hospital in Hinds County
1539 for the construction of a sixty-bed long-term care nursing
1540 facility dedicated to the care and treatment of persons with
1541 severe disabilities including persons with spinal cord and
1542 closed-head injuries and ventilator-dependent patients. The
1543 provision of Section 41-7-193(1) regarding substantial compliance
1544 with projection of need as reported in the current State Health
1545 Plan is hereby waived for the purpose of this paragraph.

1546 (m) The State Department of Health may issue a
1547 certificate of need to a county-owned hospital in the Second
1548 Judicial District of Panola County for the conversion of not more
1549 than seventy-two (72) hospital beds to nursing facility beds,
1550 provided that the recipient of the certificate of need agrees in
1551 writing that none of the beds at the nursing facility will be
1552 certified for participation in the Medicaid program (Section
1553 43-13-101 et seq.), and that no claim will be submitted for
1554 Medicaid reimbursement in the nursing facility in any day or for
1555 any patient in the nursing facility. This written agreement by
1556 the recipient of the certificate of need shall be a condition of
1557 the issuance of the certificate of need under this paragraph, and
1558 the agreement shall be fully binding on any subsequent owner of
1559 the nursing facility if the ownership of the nursing facility is

1560 transferred at any time after the issuance of the certificate of
1561 need. After this written agreement is executed, the Division of
1562 Medicaid and the State Department of Health shall not certify any
1563 of the beds in the nursing facility for participation in the
1564 Medicaid program. If the nursing facility violates the terms of
1565 the written agreement by admitting or keeping in the nursing
1566 facility on a regular or continuing basis any patients who are
1567 participating in the Medicaid program, the State Department of
1568 Health shall revoke the license of the nursing facility, at the
1569 time that the department determines, after a hearing complying
1570 with due process, that the nursing facility has violated the
1571 condition upon which the certificate of need was issued, as
1572 provided in this paragraph and in the written agreement. If the
1573 certificate of need authorized under this paragraph is not issued
1574 within twelve (12) months after July 1, 2001, the department shall
1575 deny the application for the certificate of need and shall not
1576 issue the certificate of need at any time after the twelve-month
1577 period, unless the issuance is contested. If the certificate of
1578 need is issued and substantial construction of the nursing
1579 facility beds has not commenced within eighteen (18) months after
1580 July 1, 2001, the State Department of Health, after a hearing
1581 complying with due process, shall revoke the certificate of need
1582 if it is still outstanding, and the department shall not issue a
1583 license for the nursing facility at any time after the
1584 eighteen-month period. Provided, however, that if the issuance of
1585 the certificate of need is contested, the department shall require
1586 substantial construction of the nursing facility beds within six
1587 (6) months after final adjudication on the issuance of the
1588 certificate of need.

1589 (n) The department may issue a certificate of need for
1590 the new construction, addition or conversion of skilled nursing
1591 facility beds in Madison County, provided that the recipient of
1592 the certificate of need agrees in writing that the skilled nursing
1593 facility will not at any time participate in the Medicaid program
1594 (Section 43-13-101 et seq.) or admit or keep any patients in the
1595 skilled nursing facility who are participating in the Medicaid

1596 program. This written agreement by the recipient of the
1597 certificate of need shall be fully binding on any subsequent owner
1598 of the skilled nursing facility, if the ownership of the facility
1599 is transferred at any time after the issuance of the certificate
1600 of need. Agreement that the skilled nursing facility will not
1601 participate in the Medicaid program shall be a condition of the
1602 issuance of a certificate of need to any person under this
1603 paragraph (n), and if such skilled nursing facility at any time
1604 after the issuance of the certificate of need, regardless of the
1605 ownership of the facility, participates in the Medicaid program or
1606 admits or keeps any patients in the facility who are participating
1607 in the Medicaid program, the State Department of Health shall
1608 revoke the certificate of need, if it is still outstanding, and
1609 shall deny or revoke the license of the skilled nursing facility,
1610 at the time that the department determines, after a hearing
1611 complying with due process, that the facility has failed to comply
1612 with any of the conditions upon which the certificate of need was
1613 issued, as provided in this paragraph and in the written agreement
1614 by the recipient of the certificate of need. The total number of
1615 nursing facility beds that may be authorized by any certificate of
1616 need issued under this paragraph (n) shall not exceed sixty (60)
1617 beds. If the certificate of need authorized under this paragraph
1618 is not issued within twelve (12) months after July 1, 1998, the
1619 department shall deny the application for the certificate of need
1620 and shall not issue the certificate of need at any time after the
1621 twelve-month period, unless the issuance is contested. If the
1622 certificate of need is issued and substantial construction of the
1623 nursing facility beds has not commenced within eighteen (18)
1624 months after the effective date of July 1, 1998, the State
1625 Department of Health, after a hearing complying with due process,
1626 shall revoke the certificate of need if it is still outstanding,
1627 and the department shall not issue a license for the nursing
1628 facility at any time after the eighteen-month period. Provided,
1629 however, that if the issuance of the certificate of need is
1630 contested, the department shall require substantial construction
1631 of the nursing facility beds within six (6) months after final

1632 adjudication on the issuance of the certificate of need.

1633 (o) The department may issue a certificate of need for
1634 the new construction, addition or conversion of skilled nursing
1635 facility beds in Leake County, provided that the recipient of the
1636 certificate of need agrees in writing that the skilled nursing
1637 facility will not at any time participate in the Medicaid program
1638 (Section 43-13-101 et seq.) or admit or keep any patients in the
1639 skilled nursing facility who are participating in the Medicaid
1640 program. This written agreement by the recipient of the
1641 certificate of need shall be fully binding on any subsequent owner
1642 of the skilled nursing facility, if the ownership of the facility
1643 is transferred at any time after the issuance of the certificate
1644 of need. Agreement that the skilled nursing facility will not
1645 participate in the Medicaid program shall be a condition of the
1646 issuance of a certificate of need to any person under this
1647 paragraph (o), and if such skilled nursing facility at any time
1648 after the issuance of the certificate of need, regardless of the
1649 ownership of the facility, participates in the Medicaid program or
1650 admits or keeps any patients in the facility who are participating
1651 in the Medicaid program, the State Department of Health shall
1652 revoke the certificate of need, if it is still outstanding, and
1653 shall deny or revoke the license of the skilled nursing facility,
1654 at the time that the department determines, after a hearing
1655 complying with due process, that the facility has failed to comply
1656 with any of the conditions upon which the certificate of need was
1657 issued, as provided in this paragraph and in the written agreement
1658 by the recipient of the certificate of need. The total number of
1659 nursing facility beds that may be authorized by any certificate of
1660 need issued under this paragraph (o) shall not exceed sixty (60)
1661 beds. If the certificate of need authorized under this paragraph
1662 is not issued within twelve (12) months after July 1, 2001, the
1663 department shall deny the application for the certificate of need
1664 and shall not issue the certificate of need at any time after the
1665 twelve-month period, unless the issuance is contested. If the
1666 certificate of need is issued and substantial construction of the
1667 nursing facility beds has not commenced within eighteen (18)

1668 months after the effective date of July 1, 2001, the State
1669 Department of Health, after a hearing complying with due process,
1670 shall revoke the certificate of need if it is still outstanding,
1671 and the department shall not issue a license for the nursing
1672 facility at any time after the eighteen-month period. Provided,
1673 however, that if the issuance of the certificate of need is
1674 contested, the department shall require substantial construction
1675 of the nursing facility beds within six (6) months after final
1676 adjudication on the issuance of the certificate of need.

1677 (p) The department may issue a certificate of need for
1678 the construction of a municipally-owned nursing facility within
1679 the Town of Belmont in Tishomingo County, not to exceed sixty (60)
1680 beds, provided that the recipient of the certificate of need
1681 agrees in writing that the skilled nursing facility will not at
1682 any time participate in the Medicaid program (Section 43-13-101 et
1683 seq.) or admit or keep any patients in the skilled nursing
1684 facility who are participating in the Medicaid program. This
1685 written agreement by the recipient of the certificate of need
1686 shall be fully binding on any subsequent owner of the skilled
1687 nursing facility, if the ownership of the facility is transferred
1688 at any time after the issuance of the certificate of need.
1689 Agreement that the skilled nursing facility will not participate
1690 in the Medicaid program shall be a condition of the issuance of a
1691 certificate of need to any person under this paragraph (p), and if
1692 such skilled nursing facility at any time after the issuance of
1693 the certificate of need, regardless of the ownership of the
1694 facility, participates in the Medicaid program or admits or keeps
1695 any patients in the facility who are participating in the Medicaid
1696 program, the State Department of Health shall revoke the
1697 certificate of need, if it is still outstanding, and shall deny or
1698 revoke the license of the skilled nursing facility, at the time
1699 that the department determines, after a hearing complying with due
1700 process, that the facility has failed to comply with any of the
1701 conditions upon which the certificate of need was issued, as
1702 provided in this paragraph and in the written agreement by the
1703 recipient of the certificate of need. The provision of Section

1704 43-7-193(1) regarding substantial compliance of the projection of
1705 need as reported in the current State Health Plan is waived for
1706 the purposes of this paragraph. If the certificate of need
1707 authorized under this paragraph is not issued within twelve (12)
1708 months after July 1, 1998, the department shall deny the
1709 application for the certificate of need and shall not issue the
1710 certificate of need at any time after the twelve-month period,
1711 unless the issuance is contested. If the certificate of need is
1712 issued and substantial construction of the nursing facility beds
1713 has not commenced within eighteen (18) months after July 1, 1998,
1714 the State Department of Health, after a hearing complying with due
1715 process, shall revoke the certificate of need if it is still
1716 outstanding, and the department shall not issue a license for the
1717 nursing facility at any time after the eighteen-month period.
1718 Provided, however, that if the issuance of the certificate of need
1719 is contested, the department shall require substantial
1720 construction of the nursing facility beds within six (6) months
1721 after final adjudication on the issuance of the certificate of
1722 need.

1723 (q) (i) Beginning on July 1, 1999, the State
1724 Department of Health shall issue certificates of need during each
1725 of the next four (4) fiscal years for the construction or
1726 expansion of nursing facility beds or the conversion of other beds
1727 to nursing facility beds in each county in the state having a need
1728 for fifty (50) or more additional nursing facility beds, as shown
1729 in the fiscal year 1999 State Health Plan, in the manner provided
1730 in this paragraph (q). The total number of nursing facility beds
1731 that may be authorized by any certificate of need authorized under
1732 this paragraph (q) shall not exceed sixty (60) beds.

1733 (ii) Subject to the provisions of subparagraph
1734 (v), during each of the next four (4) fiscal years, the department
1735 shall issue six (6) certificates of need for new nursing facility
1736 beds, as follows: During fiscal years 2000, 2001 and 2002, one
1737 (1) certificate of need shall be issued for new nursing facility
1738 beds in the county in each of the four (4) Long-Term Care Planning
1739 Districts designated in the fiscal year 1999 State Health Plan

1740 that has the highest need in the district for those beds; and two
1741 (2) certificates of need shall be issued for new nursing facility
1742 beds in the two (2) counties from the state at large that have the
1743 highest need in the state for those beds, when considering the
1744 need on a statewide basis and without regard to the Long-Term Care
1745 Planning Districts in which the counties are located. During
1746 fiscal year 2003, one (1) certificate of need shall be issued for
1747 new nursing facility beds in any county having a need for fifty
1748 (50) or more additional nursing facility beds, as shown in the
1749 fiscal year 1999 State Health Plan, that has not received a
1750 certificate of need under this paragraph (q) during the three (3)
1751 previous fiscal years. During fiscal year 2000, in addition to
1752 the six (6) certificates of need authorized in this subparagraph,
1753 the department also shall issue a certificate of need for new
1754 nursing facility beds in Amite County and a certificate of need
1755 for new nursing facility beds in Carroll County.

1756 (iii) Subject to the provisions of subparagraph
1757 (v), the certificate of need issued under subparagraph (ii) for
1758 nursing facility beds in each Long-Term Care Planning District
1759 during each fiscal year shall first be available for nursing
1760 facility beds in the county in the district having the highest
1761 need for those beds, as shown in the fiscal year 1999 State Health
1762 Plan. If there are no applications for a certificate of need for
1763 nursing facility beds in the county having the highest need for
1764 those beds by the date specified by the department, then the
1765 certificate of need shall be available for nursing facility beds
1766 in other counties in the district in descending order of the need
1767 for those beds, from the county with the second highest need to
1768 the county with the lowest need, until an application is received
1769 for nursing facility beds in an eligible county in the district.

1770 (iv) Subject to the provisions of subparagraph
1771 (v), the certificate of need issued under subparagraph (ii) for
1772 nursing facility beds in the two (2) counties from the state at
1773 large during each fiscal year shall first be available for nursing
1774 facility beds in the two (2) counties that have the highest need
1775 in the state for those beds, as shown in the fiscal year 1999

1776 State Health Plan, when considering the need on a statewide basis
1777 and without regard to the Long-Term Care Planning Districts in
1778 which the counties are located. If there are no applications for
1779 a certificate of need for nursing facility beds in either of the
1780 two (2) counties having the highest need for those beds on a
1781 statewide basis by the date specified by the department, then the
1782 certificate of need shall be available for nursing facility beds
1783 in other counties from the state at large in descending order of
1784 the need for those beds on a statewide basis, from the county with
1785 the second highest need to the county with the lowest need, until
1786 an application is received for nursing facility beds in an
1787 eligible county from the state at large.

1788 (v) If a certificate of need is authorized to be
1789 issued under this paragraph (q) for nursing facility beds in a
1790 county on the basis of the need in the Long-Term Care Planning
1791 District during any fiscal year of the four-year period, a
1792 certificate of need shall not also be available under this
1793 paragraph (q) for additional nursing facility beds in that county
1794 on the basis of the need in the state at large, and that county
1795 shall be excluded in determining which counties have the highest
1796 need for nursing facility beds in the state at large for that
1797 fiscal year. After a certificate of need has been issued under
1798 this paragraph (q) for nursing facility beds in a county during
1799 any fiscal year of the four-year period, a certificate of need
1800 shall not be available again under this paragraph (q) for
1801 additional nursing facility beds in that county during the
1802 four-year period, and that county shall be excluded in determining
1803 which counties have the highest need for nursing facility beds in
1804 succeeding fiscal years.

1805 (vi) If more than one (1) application is made for
1806 a certificate of need for nursing home facility beds available
1807 under this paragraph (q), in Yalobusha, Newton or Tallahatchie
1808 County, and one (1) of the applicants is a county-owned hospital
1809 located in the county where the nursing facility beds are
1810 available, the department shall give priority to the county-owned
1811 hospital in granting the certificate of need if the following

1812 conditions are met:

1813 1. The county-owned hospital fully meets all
1814 applicable criteria and standards required to obtain a certificate
1815 of need for the nursing facility beds; and

1816 2. The county-owned hospital's qualifications
1817 for the certificate of need, as shown in its application and as
1818 determined by the department, are at least equal to the
1819 qualifications of the other applicants for the certificate of
1820 need.

1821 (r) (i) Beginning on July 1, 1999, the State
1822 Department of Health shall issue certificates of need during each
1823 of the next two (2) fiscal years for the construction or expansion
1824 of nursing facility beds or the conversion of other beds to
1825 nursing facility beds in each of the four (4) Long-Term Care
1826 Planning Districts designated in the fiscal year 1999 State Health
1827 Plan, to provide care exclusively to patients with Alzheimer's
1828 disease.

1829 (ii) Not more than twenty (20) beds may be
1830 authorized by any certificate of need issued under this paragraph
1831 (r), and not more than a total of sixty (60) beds may be
1832 authorized in any Long-Term Care Planning District by all
1833 certificates of need issued under this paragraph (r). However,
1834 the total number of beds that may be authorized by all
1835 certificates of need issued under this paragraph (r) during any
1836 fiscal year shall not exceed one hundred twenty (120) beds, and
1837 the total number of beds that may be authorized in any Long-Term
1838 Care Planning District during any fiscal year shall not exceed
1839 forty (40) beds. Of the certificates of need that are issued for
1840 each Long-Term Care Planning District during the next two (2)
1841 fiscal years, at least one (1) shall be issued for beds in the
1842 northern part of the district, at least one (1) shall be issued
1843 for beds in the central part of the district, and at least one (1)
1844 shall be issued for beds in the southern part of the district.

1845 (iii) The State Department of Health, in
1846 consultation with the Department of Mental Health and the Division
1847 of Medicaid, shall develop and prescribe the staffing levels,

1848 space requirements and other standards and requirements that must
1849 be met with regard to the nursing facility beds authorized under
1850 this paragraph (r) to provide care exclusively to patients with
1851 Alzheimer's disease.

1852 (3) The State Department of Health may grant approval for
1853 and issue certificates of need to any person proposing the new
1854 construction of, addition to, conversion of beds of or expansion
1855 of any health care facility defined in subparagraph (x)
1856 (psychiatric residential treatment facility) of Section
1857 41-7-173(h). The total number of beds which may be authorized by
1858 such certificates of need shall not exceed three hundred
1859 thirty-four (334) beds for the entire state.

1860 (a) Of the total number of beds authorized under this
1861 subsection, the department shall issue a certificate of need to a
1862 privately owned psychiatric residential treatment facility in
1863 Simpson County for the conversion of sixteen (16) intermediate
1864 care facility for the mentally retarded (ICF-MR) beds to
1865 psychiatric residential treatment facility beds, provided that
1866 facility agrees in writing that the facility shall give priority
1867 for the use of those sixteen (16) beds to Mississippi residents
1868 who are presently being treated in out-of-state facilities.

1869 (b) Of the total number of beds authorized under this
1870 subsection, the department may issue a certificate or certificates
1871 of need for the construction or expansion of psychiatric
1872 residential treatment facility beds or the conversion of other
1873 beds to psychiatric residential treatment facility beds in Warren
1874 County, not to exceed sixty (60) psychiatric residential treatment
1875 facility beds, provided that the facility agrees in writing that
1876 no more than thirty (30) of the beds at the psychiatric
1877 residential treatment facility will be certified for participation
1878 in the Medicaid program (Section 43-13-101 et seq.) for the use of
1879 any patients other than those who are participating only in the
1880 Medicaid program of another state, and that no claim will be
1881 submitted to the Division of Medicaid for Medicaid reimbursement
1882 for more than thirty (30) patients in the psychiatric residential
1883 treatment facility in any day or for any patient in the

1884 psychiatric residential treatment facility who is in a bed that is
1885 not Medicaid-certified. This written agreement by the recipient
1886 of the certificate of need shall be a condition of the issuance of
1887 the certificate of need under this paragraph, and the agreement
1888 shall be fully binding on any subsequent owner of the psychiatric
1889 residential treatment facility if the ownership of the facility is
1890 transferred at any time after the issuance of the certificate of
1891 need. After this written agreement is executed, the Division of
1892 Medicaid and the State Department of Health shall not certify more
1893 than thirty (30) of the beds in the psychiatric residential
1894 treatment facility for participation in the Medicaid program for
1895 the use of any patients other than those who are participating
1896 only in the Medicaid program of another state. If the psychiatric
1897 residential treatment facility violates the terms of the written
1898 agreement by admitting or keeping in the facility on a regular or
1899 continuing basis more than thirty (30) patients who are
1900 participating in the Mississippi Medicaid program, the State
1901 Department of Health shall revoke the license of the facility, at
1902 the time that the department determines, after a hearing complying
1903 with due process, that the facility has violated the condition
1904 upon which the certificate of need was issued, as provided in this
1905 paragraph and in the written agreement.

1906 The State Department of Health, on or before July 1, 2002,
1907 shall transfer the certificate of need authorized under the
1908 authority of this paragraph (b), or reissue the certificate of
1909 need if it has expired, to River Region Health System.

1910 (c) Of the total number of beds authorized under this
1911 subsection, the department shall issue a certificate of need to a
1912 hospital currently operating Medicaid-certified acute psychiatric
1913 beds for adolescents in DeSoto County, for the establishment of a
1914 forty-bed psychiatric residential treatment facility in DeSoto
1915 County, provided that the hospital agrees in writing (i) that the
1916 hospital shall give priority for the use of those forty (40) beds
1917 to Mississippi residents who are presently being treated in
1918 out-of-state facilities, and (ii) that no more than fifteen (15)
1919 of the beds at the psychiatric residential treatment facility will

1920 be certified for participation in the Medicaid program (Section
1921 43-13-101 et seq.), and that no claim will be submitted for
1922 Medicaid reimbursement for more than fifteen (15) patients in the
1923 psychiatric residential treatment facility in any day or for any
1924 patient in the psychiatric residential treatment facility who is
1925 in a bed that is not Medicaid-certified. This written agreement
1926 by the recipient of the certificate of need shall be a condition
1927 of the issuance of the certificate of need under this paragraph,
1928 and the agreement shall be fully binding on any subsequent owner
1929 of the psychiatric residential treatment facility if the ownership
1930 of the facility is transferred at any time after the issuance of
1931 the certificate of need. After this written agreement is
1932 executed, the Division of Medicaid and the State Department of
1933 Health shall not certify more than fifteen (15) of the beds in the
1934 psychiatric residential treatment facility for participation in
1935 the Medicaid program. If the psychiatric residential treatment
1936 facility violates the terms of the written agreement by admitting
1937 or keeping in the facility on a regular or continuing basis more
1938 than fifteen (15) patients who are participating in the Medicaid
1939 program, the State Department of Health shall revoke the license
1940 of the facility, at the time that the department determines, after
1941 a hearing complying with due process, that the facility has
1942 violated the condition upon which the certificate of need was
1943 issued, as provided in this paragraph and in the written
1944 agreement.

1945 (d) Of the total number of beds authorized under this
1946 subsection, the department may issue a certificate or certificates
1947 of need for the construction or expansion of psychiatric
1948 residential treatment facility beds or the conversion of other
1949 beds to psychiatric treatment facility beds, not to exceed thirty
1950 (30) psychiatric residential treatment facility beds, in either
1951 Alcorn, Tishomingo, Prentiss, Lee, Itawamba, Monroe, Chickasaw,
1952 Pontotoc, Calhoun, Lafayette, Union, Benton or Tippah Counties.

1953 (e) Of the total number of beds authorized under this
1954 subsection (3) the department shall issue a certificate of need to
1955 a privately owned, nonprofit psychiatric residential treatment

1956 facility in Hinds County for an eight-bed expansion of the
1957 facility, provided that the facility agrees in writing that the
1958 facility shall give priority for the use of those eight (8) beds
1959 to Mississippi residents who are presently being treated in
1960 out-of-state facilities.

1961 (f) The department shall issue a certificate of need to
1962 a one-hundred-thirty-four-bed specialty hospital located on
1963 twenty-nine and forty-four one-hundredths (29.44) commercial acres
1964 at 5900 Highway 39 North in Meridian (Lauderdale County),
1965 Mississippi, for the addition, construction or expansion of
1966 child/adolescent psychiatric residential treatment facility beds
1967 in Lauderdale County. As a condition of issuance of the
1968 certificate of need under this paragraph, the facility shall give
1969 priority in admissions to the child/adolescent psychiatric
1970 residential treatment facility beds authorized under this
1971 paragraph to patients who otherwise would require out-of-state
1972 placement. The Division of Medicaid, in conjunction with the
1973 Department of Human Services, shall furnish the facility a list of
1974 all out-of-state patients on a quarterly basis. Furthermore,
1975 notice shall also be provided to the parent, custodial parent or
1976 guardian of each out-of-state patient notifying them of the
1977 priority status granted by this paragraph. For purposes of this
1978 paragraph, the provisions of Section 41-7-193(1) requiring
1979 substantial compliance with the projection of need as reported in
1980 the current State Health Plan are waived. The total number of
1981 child/adolescent psychiatric residential treatment facility beds
1982 that may be authorized under the authority of this paragraph shall
1983 be sixty (60) beds. There shall be no prohibition or restrictions
1984 on participation in the Medicaid program (Section 43-13-101 et
1985 seq.) for the person receiving the certificate of need authorized
1986 under this paragraph or for the beds converted pursuant to the
1987 authority of that certificate of need.

1988 (4) (a) From and after July 1, 1993, the department shall
1989 not issue a certificate of need to any person for the new
1990 construction of any hospital, psychiatric hospital or chemical
1991 dependency hospital that will contain any child/adolescent

1992 psychiatric or child/adolescent chemical dependency beds, or for
1993 the conversion of any other health care facility to a hospital,
1994 psychiatric hospital or chemical dependency hospital that will
1995 contain any child/adolescent psychiatric or child/adolescent
1996 chemical dependency beds, or for the addition of any
1997 child/adolescent psychiatric or child/adolescent chemical
1998 dependency beds in any hospital, psychiatric hospital or chemical
1999 dependency hospital, or for the conversion of any beds of another
2000 category in any hospital, psychiatric hospital or chemical
2001 dependency hospital to child/adolescent psychiatric or
2002 child/adolescent chemical dependency beds, except as hereinafter
2003 authorized:

2004 (i) The department may issue certificates of need
2005 to any person for any purpose described in this subsection,
2006 provided that the hospital, psychiatric hospital or chemical
2007 dependency hospital does not participate in the Medicaid program
2008 (Section 43-13-101 et seq.) at the time of the application for the
2009 certificate of need and the owner of the hospital, psychiatric
2010 hospital or chemical dependency hospital agrees in writing that
2011 the hospital, psychiatric hospital or chemical dependency hospital
2012 will not at any time participate in the Medicaid program or admit
2013 or keep any patients who are participating in the Medicaid program
2014 in the hospital, psychiatric hospital or chemical dependency
2015 hospital. This written agreement by the recipient of the
2016 certificate of need shall be fully binding on any subsequent owner
2017 of the hospital, psychiatric hospital or chemical dependency
2018 hospital, if the ownership of the facility is transferred at any
2019 time after the issuance of the certificate of need. Agreement
2020 that the hospital, psychiatric hospital or chemical dependency
2021 hospital will not participate in the Medicaid program shall be a
2022 condition of the issuance of a certificate of need to any person
2023 under this subparagraph (a)(i), and if such hospital, psychiatric
2024 hospital or chemical dependency hospital at any time after the
2025 issuance of the certificate of need, regardless of the ownership
2026 of the facility, participates in the Medicaid program or admits or
2027 keeps any patients in the hospital, psychiatric hospital or

2028 chemical dependency hospital who are participating in the Medicaid
2029 program, the State Department of Health shall revoke the
2030 certificate of need, if it is still outstanding, and shall deny or
2031 revoke the license of the hospital, psychiatric hospital or
2032 chemical dependency hospital, at the time that the department
2033 determines, after a hearing complying with due process, that the
2034 hospital, psychiatric hospital or chemical dependency hospital has
2035 failed to comply with any of the conditions upon which the
2036 certificate of need was issued, as provided in this subparagraph
2037 and in the written agreement by the recipient of the certificate
2038 of need.

2039 (ii) The department may issue a certificate of
2040 need for the conversion of existing beds in a county hospital in
2041 Choctaw County from acute care beds to child/adolescent chemical
2042 dependency beds. For purposes of this subparagraph, the
2043 provisions of Section 41-7-193(1) requiring substantial compliance
2044 with the projection of need as reported in the current State
2045 Health Plan is waived. The total number of beds that may be
2046 authorized under authority of this subparagraph shall not exceed
2047 twenty (20) beds. There shall be no prohibition or restrictions
2048 on participation in the Medicaid program (Section 43-13-101 et
2049 seq.) for the hospital receiving the certificate of need
2050 authorized under this subparagraph (a)(ii) or for the beds
2051 converted pursuant to the authority of that certificate of need.

2052 (iii) The department may issue a certificate or
2053 certificates of need for the construction or expansion of
2054 child/adolescent psychiatric beds or the conversion of other beds
2055 to child/adolescent psychiatric beds in Warren County. For
2056 purposes of this subparagraph, the provisions of Section
2057 41-7-193(1) requiring substantial compliance with the projection
2058 of need as reported in the current State Health Plan are waived.
2059 The total number of beds that may be authorized under the
2060 authority of this subparagraph shall not exceed twenty (20) beds.

2061 There shall be no prohibition or restrictions on participation in
2062 the Medicaid program (Section 43-13-101 et seq.) for the person
2063 receiving the certificate of need authorized under this

2064 subparagraph (a)(iii) or for the beds converted pursuant to the
2065 authority of that certificate of need.

2066 If by January 1, 2002, there has been no significant
2067 commencement of construction of the beds authorized under this
2068 subparagraph (a)(iii), or no significant action taken to convert
2069 existing beds to the beds authorized under this subparagraph, then
2070 the certificate of need that was previously issued under this
2071 subparagraph shall expire. If the previously issued certificate
2072 of need expires, the department may accept applications for
2073 issuance of another certificate of need for the beds authorized
2074 under this subparagraph, and may issue a certificate of need to
2075 authorize the construction, expansion or conversion of the beds
2076 authorized under this subparagraph.

2077 (iv) The department shall issue a certificate of
2078 need to the Region 7 Mental Health/Retardation Commission for the
2079 construction or expansion of child/adolescent psychiatric beds or
2080 the conversion of other beds to child/adolescent psychiatric beds
2081 in any of the counties served by the commission. For purposes of
2082 this subparagraph, the provisions of Section 41-7-193(1) requiring
2083 substantial compliance with the projection of need as reported in
2084 the current State Health Plan is waived. The total number of beds
2085 that may be authorized under the authority of this subparagraph
2086 shall not exceed twenty (20) beds. There shall be no prohibition
2087 or restrictions on participation in the Medicaid program (Section
2088 43-13-101 et seq.) for the person receiving the certificate of
2089 need authorized under this subparagraph (a)(iv) or for the beds
2090 converted pursuant to the authority of that certificate of need.

2091 (v) The department may issue a certificate of need
2092 to any county hospital located in Leflore County for the
2093 construction or expansion of adult psychiatric beds or the
2094 conversion of other beds to adult psychiatric beds, not to exceed
2095 twenty (20) beds, provided that the recipient of the certificate
2096 of need agrees in writing that the adult psychiatric beds will not
2097 at any time be certified for participation in the Medicaid program
2098 and that the hospital will not admit or keep any patients who are
2099 participating in the Medicaid program in any of such adult

2100 psychiatric beds. This written agreement by the recipient of the
2101 certificate of need shall be fully binding on any subsequent owner
2102 of the hospital if the ownership of the hospital is transferred at
2103 any time after the issuance of the certificate of need. Agreement
2104 that the adult psychiatric beds will not be certified for
2105 participation in the Medicaid program shall be a condition of the
2106 issuance of a certificate of need to any person under this
2107 subparagraph (a)(v), and if such hospital at any time after the
2108 issuance of the certificate of need, regardless of the ownership
2109 of the hospital, has any of such adult psychiatric beds certified
2110 for participation in the Medicaid program or admits or keeps any
2111 Medicaid patients in such adult psychiatric beds, the State
2112 Department of Health shall revoke the certificate of need, if it
2113 is still outstanding, and shall deny or revoke the license of the
2114 hospital at the time that the department determines, after a
2115 hearing complying with due process, that the hospital has failed
2116 to comply with any of the conditions upon which the certificate of
2117 need was issued, as provided in this subparagraph and in the
2118 written agreement by the recipient of the certificate of need.

2119 (vi) The department may issue a certificate or
2120 certificates of need for the expansion of child psychiatric beds
2121 or the conversion of other beds to child psychiatric beds at the
2122 University of Mississippi Medical Center. For purposes of this
2123 subparagraph (a)(vi), the provision of Section 41-7-193(1)
2124 requiring substantial compliance with the projection of need as
2125 reported in the current State Health Plan is waived. The total
2126 number of beds that may be authorized under the authority of this
2127 subparagraph (a)(vi) shall not exceed fifteen (15) beds. There
2128 shall be no prohibition or restrictions on participation in the
2129 Medicaid program (Section 43-13-101 et seq.) for the hospital
2130 receiving the certificate of need authorized under this
2131 subparagraph (a)(vi) or for the beds converted pursuant to the
2132 authority of that certificate of need.

2133 (b) From and after July 1, 1990, no hospital,
2134 psychiatric hospital or chemical dependency hospital shall be
2135 authorized to add any child/adolescent psychiatric or

2136 child/adolescent chemical dependency beds or convert any beds of
2137 another category to child/adolescent psychiatric or
2138 child/adolescent chemical dependency beds without a certificate of
2139 need under the authority of subsection (1)(c) of this section.

2140 (5) The department may issue a certificate of need to a
2141 county hospital in Winston County for the conversion of fifteen
2142 (15) acute care beds to geriatric psychiatric care beds.

2143 (6) The State Department of Health shall issue a certificate
2144 of need to a Mississippi corporation qualified to manage a
2145 long-term care hospital as defined in Section 41-7-173(h)(xii) in
2146 Harrison County, not to exceed eighty (80) beds, including any
2147 necessary renovation or construction required for licensure and
2148 certification, provided that the recipient of the certificate of
2149 need agrees in writing that the long-term care hospital will not
2150 at any time participate in the Medicaid program (Section 43-13-101
2151 et seq.) or admit or keep any patients in the long-term care
2152 hospital who are participating in the Medicaid program. This
2153 written agreement by the recipient of the certificate of need
2154 shall be fully binding on any subsequent owner of the long-term
2155 care hospital, if the ownership of the facility is transferred at
2156 any time after the issuance of the certificate of need. Agreement
2157 that the long-term care hospital will not participate in the
2158 Medicaid program shall be a condition of the issuance of a
2159 certificate of need to any person under this subsection (6), and
2160 if such long-term care hospital at any time after the issuance of
2161 the certificate of need, regardless of the ownership of the
2162 facility, participates in the Medicaid program or admits or keeps
2163 any patients in the facility who are participating in the Medicaid
2164 program, the State Department of Health shall revoke the
2165 certificate of need, if it is still outstanding, and shall deny or
2166 revoke the license of the long-term care hospital, at the time
2167 that the department determines, after a hearing complying with due
2168 process, that the facility has failed to comply with any of the
2169 conditions upon which the certificate of need was issued, as
2170 provided in this subsection and in the written agreement by the
2171 recipient of the certificate of need. For purposes of this

2172 subsection, the provision of Section 41-7-193(1) requiring
2173 substantial compliance with the projection of need as reported in
2174 the current State Health Plan is hereby waived.

2175 (7) The State Department of Health may issue a certificate
2176 of need to any hospital in the state to utilize a portion of its
2177 beds for the "swing-bed" concept. Any such hospital must be in
2178 conformance with the federal regulations regarding such swing-bed
2179 concept at the time it submits its application for a certificate
2180 of need to the State Department of Health, except that such
2181 hospital may have more licensed beds or a higher average daily
2182 census (ADC) than the maximum number specified in federal
2183 regulations for participation in the swing-bed program. Any
2184 hospital meeting all federal requirements for participation in the
2185 swing-bed program which receives such certificate of need shall
2186 render services provided under the swing-bed concept to any
2187 patient eligible for Medicare (Title XVIII of the Social Security
2188 Act) who is certified by a physician to be in need of such
2189 services, and no such hospital shall permit any patient who is
2190 eligible for both Medicaid and Medicare or eligible only for
2191 Medicaid to stay in the swing beds of the hospital for more than
2192 thirty (30) days per admission unless the hospital receives prior
2193 approval for such patient from the Division of Medicaid, Office of
2194 the Governor. Any hospital having more licensed beds or a higher
2195 average daily census (ADC) than the maximum number specified in
2196 federal regulations for participation in the swing-bed program
2197 which receives such certificate of need shall develop a procedure
2198 to insure that before a patient is allowed to stay in the swing
2199 beds of the hospital, there are no vacant nursing home beds
2200 available for that patient located within a fifty-mile radius of
2201 the hospital. When any such hospital has a patient staying in the
2202 swing beds of the hospital and the hospital receives notice from a
2203 nursing home located within such radius that there is a vacant bed
2204 available for that patient, the hospital shall transfer the
2205 patient to the nursing home within a reasonable time after receipt
2206 of the notice. Any hospital which is subject to the requirements
2207 of the two (2) preceding sentences of this subsection may be

2208 suspended from participation in the swing-bed program for a
2209 reasonable period of time by the State Department of Health if the
2210 department, after a hearing complying with due process, determines
2211 that the hospital has failed to comply with any of those
2212 requirements.

2213 (8) The Department of Health shall not grant approval for or
2214 issue a certificate of need to any person proposing the new
2215 construction of, addition to or expansion of a health care
2216 facility as defined in subparagraph (viii) of Section 41-7-173(h).

2217 (9) The Department of Health shall not grant approval for or
2218 issue a certificate of need to any person proposing the
2219 establishment of, or expansion of the currently approved territory
2220 of, or the contracting to establish a home office, subunit or
2221 branch office within the space operated as a health care facility
2222 as defined in Section 41-7-173(h) (i) through (viii) by a health
2223 care facility as defined in subparagraph (ix) of Section
2224 41-7-173(h).

2225 (10) Health care facilities owned and/or operated by the
2226 state or its agencies are exempt from the restraints in this
2227 section against issuance of a certificate of need if such addition
2228 or expansion consists of repairing or renovation necessary to
2229 comply with the state licensure law. This exception shall not
2230 apply to the new construction of any building by such state
2231 facility. This exception shall not apply to any health care
2232 facilities owned and/or operated by counties, municipalities,
2233 districts, unincorporated areas, other defined persons, or any
2234 combination thereof.

2235 (11) The new construction, renovation or expansion of or
2236 addition to any health care facility defined in subparagraph (ii)
2237 (psychiatric hospital), subparagraph (iv) (skilled nursing
2238 facility), subparagraph (vi) (intermediate care facility),
2239 subparagraph (viii) (intermediate care facility for the mentally
2240 retarded) and subparagraph (x) (psychiatric residential treatment
2241 facility) of Section 41-7-173(h) which is owned by the State of
2242 Mississippi and under the direction and control of the State
2243 Department of Mental Health, and the addition of new beds or the

2244 conversion of beds from one category to another in any such
2245 defined health care facility which is owned by the State of
2246 Mississippi and under the direction and control of the State
2247 Department of Mental Health, shall not require the issuance of a
2248 certificate of need under Section 41-7-171 et seq.,
2249 notwithstanding any provision in Section 41-7-171 et seq. to the
2250 contrary.

2251 (12) The new construction, renovation or expansion of or
2252 addition to any veterans homes or domiciliaries for eligible
2253 veterans of the State of Mississippi as authorized under Section
2254 35-1-19 shall not require the issuance of a certificate of need,
2255 notwithstanding any provision in Section 41-7-171 et seq. to the
2256 contrary.

2257 (13) The new construction of a nursing facility or nursing
2258 facility beds or the conversion of other beds to nursing facility
2259 beds shall not require the issuance of a certificate of need,
2260 notwithstanding any provision in Section 41-7-171 et seq. to the
2261 contrary, if the conditions of this subsection are met.

2262 (a) Before any construction or conversion may be
2263 undertaken without a certificate of need, the owner of the nursing
2264 facility, in the case of an existing facility, or the applicant to
2265 construct a nursing facility, in the case of new construction,
2266 first must file a written notice of intent and sign a written
2267 agreement with the State Department of Health that the entire
2268 nursing facility will not at any time participate in or have any
2269 beds certified for participation in the Medicaid program (Section
2270 43-13-101 et seq.), will not admit or keep any patients in the
2271 nursing facility who are participating in the Medicaid program,
2272 and will not submit any claim for Medicaid reimbursement for any
2273 patient in the facility. This written agreement by the owner or
2274 applicant shall be a condition of exercising the authority under
2275 this subsection without a certificate of need, and the agreement
2276 shall be fully binding on any subsequent owner of the nursing
2277 facility if the ownership of the facility is transferred at any
2278 time after the agreement is signed. After the written agreement
2279 is signed, the Division of Medicaid and the State Department of

2280 Health shall not certify any beds in the nursing facility for
2281 participation in the Medicaid program. If the nursing facility
2282 violates the terms of the written agreement by participating in
2283 the Medicaid program, having any beds certified for participation
2284 in the Medicaid program, admitting or keeping any patient in the
2285 facility who is participating in the Medicaid program, or
2286 submitting any claim for Medicaid reimbursement for any patient in
2287 the facility, the State Department of Health shall revoke the
2288 license of the nursing facility at the time that the department
2289 determines, after a hearing complying with due process, that the
2290 facility has violated the terms of the written agreement.

2291 (b) For the purposes of this subsection, participation
2292 in the Medicaid program by a nursing facility includes Medicaid
2293 reimbursement of coinsurance and deductibles for recipients who
2294 are qualified Medicare beneficiaries and/or those who are dually
2295 eligible. Any nursing facility exercising the authority under
2296 this subsection may not bill or submit a claim to the Division of
2297 Medicaid for services to qualified Medicare beneficiaries and/or
2298 those who are dually eligible.

2299 (c) The new construction of a nursing facility or
2300 nursing facility beds or the conversion of other beds to nursing
2301 facility beds described in this section must be either a part of a
2302 completely new continuing care retirement community, as described
2303 in the latest edition of the Mississippi State Health Plan, or an
2304 addition to existing personal care and independent living
2305 components, and so that the completed project will be a continuing
2306 care retirement community, containing (i) independent living
2307 accommodations, (ii) personal care beds, and (iii) the nursing
2308 home facility beds. The three (3) components must be located on a
2309 single site and be operated as one (1) inseparable facility. The
2310 nursing facility component must contain a minimum of thirty (30)
2311 beds. Any nursing facility beds authorized by this section will
2312 not be counted against the bed need set forth in the State Health
2313 Plan, as identified in Section 41-7-171, et seq.

2314 This subsection (13) shall stand repealed from and after July
2315 1, 2005.

2316 (14) The State Department of Health shall issue a
2317 certificate of need to any hospital which is currently licensed
2318 for two hundred fifty (250) or more acute care beds and is located
2319 in any general hospital service area not having a comprehensive
2320 cancer center, for the establishment and equipping of such a
2321 center which provides facilities and services for outpatient
2322 radiation oncology therapy, outpatient medical oncology therapy,
2323 and appropriate support services including the provision of
2324 radiation therapy services. The provision of Section 41-7-193(1)
2325 regarding substantial compliance with the projection of need as
2326 reported in the current State Health Plan is waived for the
2327 purpose of this subsection.

2328 (15) The State Department of Health may authorize the
2329 transfer of hospital beds, not to exceed sixty (60) beds, from the
2330 North Panola Community Hospital to the South Panola Community
2331 Hospital. The authorization for the transfer of those beds shall
2332 be exempt from the certificate of need review process.

2333 (16) Nothing in this section or in any other provision of
2334 Section 41-7-171 et seq. shall prevent any nursing facility from
2335 designating an appropriate number of existing beds in the facility
2336 as beds for providing care exclusively to patients with
2337 Alzheimer's disease.

2338 **SECTION 7.** Any transfer of funds to the Department of Mental
2339 Health by a political subdivision or instrumentality of the state
2340 before the effective date of Senate Bill No. 2189, 2002 Regular
2341 Session, which funds were used to match federal funds to provide
2342 services under paragraph (29) of Section 43-13-117, is ratified,
2343 approved and confirmed.

2344 **SECTION 8.** This act shall take effect and be in force from
2345 and after its passage.

**Further, amend by striking the title in its entirety and
inserting in lieu thereof the following:**

1 AN ACT TO AMEND SECTION 43-13-117, AS AMENDED BY HOUSE BILL
2 NO. 1200 AND SENATE BILL NO. 3060, 2002 REGULAR SESSION,
3 MISSISSIPPI CODE OF 1972, TO AUTHORIZE UNLIMITED DAY REIMBURSEMENT
4 FOR DISPROPORTIONATE SHARE PROGRAM HOSPITALS FOR ELIGIBLE CHILDREN
5 UNDER THE AGE OF SIX ONLY IF CERTIFIED AS MEDICALLY NECESSARY; TO
6 AUTHORIZE A JOINT LEGISLATIVE STUDY COMMITTEE TO CONSIDER THE
7 ISSUE OF SETTING UNIFORM REIMBURSEMENT RATES FOR NURSING HOMES; TO

8 DELETE SPECIFIC FEE INCREASES FOR PERIODIC SCREENING AND
9 DIAGNOSTIC SERVICES; TO DIRECT THE DIVISION TO ESTABLISH A CLOSED
10 DRUG FORMULARY; TO PROVIDE THAT THE MONTHLY LIMIT ON PRESCRIPTION
11 DRUGS DOES NOT APPLY TO INSTITUTIONALIZED RECIPIENTS; TO PROVIDE
12 THAT THE PRIOR APPROVAL REQUIREMENT FOR PRESCRIPTIONS ABOVE A
13 CERTAIN NUMBER APPLIES TO ALL RECIPIENTS; TO AUTHORIZE MEDICAID
14 REIMBURSEMENT FOR MENTAL HEALTH SERVICES PROVIDED IN THE COMMUNITY
15 BY A FACILITY OR PROGRAM OPERATED BY THE DEPARTMENT OF MENTAL
16 HEALTH; TO REVISE THE CONDITIONS FOR REIMBURSEMENT OF THE COST OF
17 EYEGLASSES FOR RECIPIENTS; TO CLARIFY THE REQUIREMENT FOR
18 DISPROPORTIONATE SHARE PROGRAM HOSPITALS TO PARTICIPATE IN THE
19 FEDERAL INTERGOVERNMENTAL TRANSFER PROGRAM; TO AUTHORIZE THE
20 DIVISION OF MEDICAID TO ESTABLISH A MEDICARE UPPER PAYMENT LIMITS
21 PROGRAM FOR NURSING FACILITIES; TO CHANGE CERTAIN REFERENCES TO
22 THE FEDERAL INDIVIDUALS WITH DISABILITIES EDUCATION ACT; TO
23 AUTHORIZE MEDICAID REIMBURSEMENT TO RURAL HEALTH CENTERS FOR
24 AMBULATORY SERVICES; TO AUTHORIZE FUNDS TRANSFERRED TO THE
25 DEPARTMENT OF MENTAL HEALTH BY A POLITICAL SUBDIVISION OR
26 INSTRUMENTALITY OF THE STATE TO BE USED AS MEDICAID MATCH FOR
27 REIMBURSEMENT OF HOME- AND COMMUNITY-BASED SERVICES FOR
28 DEVELOPMENTALLY DISABLED PEOPLE; TO AUTHORIZE MEDICAID
29 REIMBURSEMENT TO CHIROPRACTORS FOR X-RAYS PERFORMED TO DOCUMENT
30 CONDITIONS; TO AUTHORIZE THE DIVISION TO APPLY FOR FEDERAL WAIVERS
31 THAT MAY ENHANCE THE POPULATION HEALTH MANAGEMENT PROGRAM; TO
32 PROVIDE MEDICAID REIMBURSEMENT FOR PEDIATRIC LONG-TERM ACUTE CARE
33 HOSPITAL SERVICES; TO EXEMPT NONEMERGENCY TRANSPORTATION SERVICES
34 FROM THE REQUIREMENT FOR A COPAYMENT; TO PROVIDE THAT THE FIVE
35 PERCENT REDUCTION IN PROVIDER REIMBURSEMENTS IMPOSED BY HOUSE BILL
36 NO. 1200, 2002 REGULAR SESSION, SHALL NOT APPLY TO THOSE HEALTH
37 CARE FACILITIES UPON WHICH AN ASSESSMENT IS LEVIED UNDER SECTION
38 43-13-145, MISSISSIPPI CODE OF 1972; TO PROVIDE THAT THE FIVE
39 PERCENT REDUCTION ALSO SHALL NOT APPLY TO CERTAIN SERVICES
40 PROVIDED BY PLANNING AND DEVELOPMENT DISTRICTS IF THE DISTRICTS
41 TRANSFER CERTAIN SUMS TO THE DIVISION; TO AMEND SECTION 43-13-121,
42 MISSISSIPPI CODE OF 1972, TO CLARIFY AND REVISE THE CONDITIONS FOR
43 DENYING OR REVOKING PROVIDER ENROLLMENT IN THE MEDICAID PROGRAM;
44 TO AMEND SECTION 43-13-123, MISSISSIPPI CODE OF 1972, TO CLARIFY
45 THAT THE DIVISION SHALL OBTAIN SERVICES IN ACCORDANCE WITH
46 REGULATIONS OF THE PERSONAL SERVICE CONTRACT REVIEW BOARD; TO
47 AMEND SECTION 43-13-127, MISSISSIPPI CODE OF 1972, TO REQUIRE THE
48 DIVISION OF MEDICAID TO SUBMIT A MONTHLY REPORT TO THE CHAIRMEN OF
49 THE SENATE AND HOUSE PUBLIC HEALTH AND WELFARE COMMITTEES AND TO
50 THE JOINT LEGISLATIVE BUDGET COMMITTEE; TO AMEND SECTION
51 43-13-145, MISSISSIPPI CODE OF 1972, TO INCREASE THE MEDICAID
52 ASSESSMENT ON NURSING HOME BEDS AND PROVIDE FOR MEDICAID
53 ASSESSMENTS ON OTHER HEALTH CARE FACILITIES; TO PROVIDE FOR THE
54 COLLECTION OF THOSE ASSESSMENTS; TO AMEND SECTION 41-7-191,
55 MISSISSIPPI CODE OF 1972, TO PROVIDE THAT THE ADDITION OR
56 CONVERSION OF ANY NUMBER OF BEDS OF A HEALTH CARE FACILITY SHALL
57 REQUIRE APPROVAL BY A CERTIFICATE OF NEED; TO DIRECT THE STATE
58 DEPARTMENT OF HEALTH TO TRANSFER A CERTAIN CERTIFICATE OF NEED
59 AUTHORIZING PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY BEDS IN
60 WARREN COUNTY; AND FOR RELATED PURPOSES.

CONFEREES FOR THE SENATE

X _____
Robert G. Huggins

X _____
Terry C. Burton

X _____
Travis L. Little

CONFEREES FOR THE HOUSE

X _____
Bobby Moody

X _____
D. Stephen Holland

X _____
George Flaggs, Jr.