By: Representatives Moody, Holland

To: Public Health and Welfare; Appropriations

HOUSE BILL NO. 896

1 AN ACT RELATIVE TO THE MISSISSIPPI MEDICAID PROGRAM; TO AMEND
2 SECTION 43-13-115, MISSISSIPPI CODE OF 1972, TO CLARIFY
3 ELIGIBILITY FOR MEDICAID; TO AUTHORIZE THE DIVISION OF MEDICAID TO
4 APPLY FOR APPLICABLE WAIVERS FOR BENEFITS AND BUY-IN OPTIONS FOR
5 THE DISABLED CHILDREN LIVING AT HOME AND POVERTY LEVEL AGED AND
6 DISABLED (PLADS) ELIGIBILITY CATEGORIES AND TO ESTABLISH AN
7 EXPENDITURE/ENROLLMENT CAP FOR THESE CATEGORIES; TO AMEND SECTION
8 43-13-117, MISSISSIPPI CODE OF 1972, TO REDUCE THE NURSING
9 FACILITY BED DAYS ELIGIBLE FOR MEDICAID REIMBURSEMENT; TO
10 AUTHORIZE THE DIVISION TO DEVELOP AN ASSESSMENT PROCESS FOR
11 LONG-TERM CARE SERVICES AND DELETE THE REFERRAL PHYSICIAN
12 CERTIFICATION PROCESS; TO DELETE THE NECESSITY TO COMPARE HOME
13 HEALTH COSTS TO NURSING FACILITY SERVICES FOR REIMBURSEMENT; TO
14 DELETE AUTHORITY FOR THE DIVISION TO OPT OUT OF THE FEDERAL DRUG
15 REBATE PROGRAM AND CREATE A CLOSED DRUG FORMULARY; TO DIRECT THE
16 DIVISION TO CONTRACT FOR FULL SCOPE PHARMACY BENEFIT MANAGEMENT,
17 INCLUDING A PREFERRED DRUG LIST, MAIL ORDER, SUPPLEMENTAL REBATES
18 AND COALITION BUYING; TO INCREASE THE AVERAGE WHOLESALE PRICE
19 (AWP) DISCOUNT AND DIRECT THE DIVISION TO DEVELOP A STATE MAXIMUM
20 ALLOWABLE COST (MAC) PRICING SCHEDULE; TO DELETE PRIOR APPROVAL OF
21 MONTHLY DRUG PRESCRIPTIONS OVER FIVE; TO ALLOW A DISPENSING FEE
22 FOR OVER-THE-COUNTER DRUGS; TO REDUCE THE ICF/MR BED DAYS ELIGIBLE
23 FOR REIMBURSEMENT; TO DELETE CERTAIN RESTRICTIONS ON THE HOME- AND
24 COMMUNITY-BASED SERVICES WAIVER PROGRAM; TO DIRECT THE DIVISION TO
25 PAY A FLAT FEE FOR NONEMERGENCY TRANSPORTATION SERVICES, OR IN THE
26 ALTERNATIVE REIMBURSE ACTUAL MILES TRAVELED AND TO APPLY FOR
27 WAIVERS TO DRAW FEDERAL FUNDS FOR NONEMERGENCY TRANSPORTATION AS A
28 COVERED SERVICE; TO DELETE THE AUTHORITY FOR REIMBURSEMENT FOR
29 BIRTHING CENTER SERVICES; TO CLARIFY THE ASSISTED LIVING SERVICES
30 WAIVER PROVISION; TO GIVE THE DIVISION DISCRETION IN PAYING
31 MEDICARE COINSURANCE AMOUNTS; TO AUTHORIZE CHILDREN UP TO TWO
32 YEARS OF AGE FOR THE OBSTETRICAL CARE WAIVER PROGRAM; TO DELETE
33 CERTAIN RESTRICTIONS IN THE DISEASE MANAGEMENT PROGRAM AUTHORITY;
34 TO REMOVE THE FIVE PERCENT REIMBURSEMENT REDUCTION FOR CASE
35 MANAGEMENT SERVICES UNDER THE HOME- AND COMMUNITY-BASED WAIVER
36 PROGRAM; AND TO AUTHORIZE THE DIVISION TO REMOVE THE FIVE PERCENT
37 REDUCTION IN REIMBURSEMENT FOR PROVIDERS WHO PARTICIPATE IN THE
38 EMERGENCY ROOM REDIRECTION PROGRAM; TO AMEND SECTION 43-13-122,
39 MISSISSIPPI CODE OF 1972, TO DELETE CERTAIN OBSOLETE LANGUAGE; TO
40 AMEND SECTION 43-13-107, MISSISSIPPI CODE OF 1972, TO AUTHORIZE
41 THE DIVISION TO SUBMIT EMERGENCY DRUG ISSUES TO THE PHARMACY AND
42 THERAPEUTICS COMMITTEE WITHOUT PUBLIC COMMENT; TO AMEND SECTION
43 43-13-145, MISSISSIPPI CODE OF 1972, TO INCREASE THE PER BED
44 ASSESSMENT LEVIED UPON NURSING FACILITIES FOR SUPPORT OF THE
45 MEDICAID PROGRAM; TO AMEND SECTION 41-7-191, MISSISSIPPI CODE OF
46 1972, TO PROHIBIT THE STATE DEPARTMENT OF HEALTH FROM ISSUING A
47 CERTIFICATE OF NEED FOR THE ADDITION, CONSTRUCTION OR CONVERSION
48 OF ANY NURSING FACILITY BEDS AFTER THE EFFECTIVE DATE OF THIS ACT,
49 AND TO INCLUDE HOME- AND COMMUNITY-BASED SERVICES IN THE STATE
50 HEALTH PLAN FOR LONG-TERM CARE CON PURPOSES; AND FOR RELATED
51 PURPOSES.

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

53 **SECTION 1.** Section 43-13-115, Mississippi Code of 1972, is
54 amended as follows:

55 43-13-115. Recipients of Medicaid shall be the following
56 persons only:

57 (1) Who are qualified for public assistance grants
58 under provisions of Title IV-A and E of the federal Social
59 Security Act, as amended, as determined by the State Department of
60 Human Services, including those statutorily deemed to be IV-A and
61 low-income families and children under Section 1931 of the Social
62 Security Act as determined by the State Department of Human
63 Services and certified to the Division of Medicaid, but not
64 optional groups except as specifically covered in this section.
65 For the purposes of this paragraph (1) and paragraphs (8), (17)
66 and (18) of this section, any reference to Title IV-A or to Part A
67 of Title IV of the federal Social Security Act, as amended, or the
68 state plan under Title IV-A or Part A of Title IV, shall be
69 considered as a reference to Title IV-A of the federal Social
70 Security Act, as amended, and the state plan under Title IV-A,
71 including the income and resource standards and methodologies
72 under Title IV-A and the state plan, as they existed on July 16,
73 1996.

74 (2) Those qualified for Supplemental Security Income
75 (SSI) benefits under Title XVI of the federal Social Security Act,
76 as amended, and those who are deemed SSI eligible as contained in
77 federal statute. The eligibility of individuals covered in this
78 paragraph shall be determined by the Social Security
79 Administration and certified to the Division of Medicaid.

80 (3) Qualified pregnant women who would be eligible for
81 Medicaid as a low income family member under Section 1931 of the
82 Social Security Act if her child was born.

83 (4) [Deleted]

84 (5) A child born on or after October 1, 1984, to a
85 woman eligible for and receiving Medicaid under the state plan on
86 the date of the child's birth shall be deemed to have applied for
87 Medicaid and to have been found eligible for Medicaid under the
88 plan on the date of that birth and will remain eligible for
89 Medicaid for a period of one (1) year so long as the child is a
90 member of the woman's household and the woman remains eligible for
91 Medicaid or would be eligible for Medicaid if pregnant. The
92 eligibility of individuals covered in this paragraph shall be
93 determined by the State Department of Human Services and certified
94 to the Division of Medicaid.
95 (6) Children certified by the State Department of Human
96 Services to the Division of Medicaid of whom the state and county
97 departments of human services have custody and financial
98 responsibility, and children who are in adoptions subsidized in
99 full or part by the Department of Human Services, including
100 special needs children in non-Title IV-E adoption assistance, who
101 are approvable under Title XIX of the Medicaid program.
102 (7) (a) Persons certified by the Division of Medicaid
103 who are patients in a medical facility (nursing home, hospital,
104 tuberculosis sanatorium or institution for treatment of mental
105 diseases), and who, except for the fact that they are patients in
106 that medical facility, would qualify for grants under Title IV,
107 Supplementary Security Income (SSI) benefits under Title XVI or
108 state supplements, and those aged, blind and disabled persons who
109 would not be eligible for Supplemental Security Income (SSI)
110 benefits under Title XVI or state supplements if they were not
111 institutionalized in a medical facility but whose income is below
112 the maximum standard set by the Division of Medicaid, which
113 standard shall not exceed that prescribed by federal regulation;
114 (b) Individuals who have elected to receive
115 hospice care benefits and who are eligible using the same criteria

116 and special income limits as those in institutions as described in
117 subparagraph (a) of this paragraph (7).

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

125 (9) Individuals who are:

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

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

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

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

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

149 Division of Medicaid; however, the division may apply to the
150 federal Centers for Medicare and Medicaid Services (CMS) for a
151 waiver that will allow flexibility in the benefit design for the
152 Disabled Children Living at Home eligibility category authorized
153 in this paragraph (10), and the division may establish an
154 expenditure/enrollment cap for this category. Nothing contained
155 in this paragraph (10) shall entitle an individual to benefits.
156 (11) Individuals who are sixty-five (65) years of age
157 or older or are disabled as determined under Section 1614(a)(3) of
158 the federal Social Security Act, as amended, and whose income does
159 not exceed one hundred thirty-five percent (135%) of the nonfarm
160 official poverty level as defined by the Office of Management and
161 Budget and revised annually, and whose resources do not exceed
162 those established by the Division of Medicaid.
163 The eligibility of individuals covered under this paragraph
164 shall be determined by the Division of Medicaid; however, the
165 division may apply to the federal Centers for Medicare and
166 Medicaid Services (CMS) for a waiver that will allow flexibility
167 in the benefit design and buy-in options for the Poverty Level
168 Aged and Disabled (PLAD) eligibility category authorized in this
169 paragraph (11), and the division may establish an
170 expenditure/enrollment cap for this category. Nothing contained
171 in this paragraph (11) shall entitle an individual to benefits.
172 (12) Individuals who are qualified Medicare
173 beneficiaries (QMB) entitled to Part A Medicare as defined under
174 Section 301, Public Law 100-360, known as the Medicare
175 Catastrophic Coverage Act of 1988, and whose income does not
176 exceed one hundred percent (100%) of the nonfarm official poverty
177 level as defined by the Office of Management and Budget and
178 revised annually.
179 The eligibility of individuals covered under this paragraph
180 shall be determined by the Division of Medicaid, and those
181 individuals determined eligible shall receive Medicare

182 cost-sharing expenses only as more fully defined by the Medicare
183 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
184 1997.

185 (13) * * * Individuals who are entitled to Medicare
186 Part A as defined in Section 4501 of the Omnibus Budget
187 Reconciliation Act of 1990, and whose income does not exceed one
188 hundred twenty percent (120%) of the nonfarm official poverty
189 level as defined by the Office of Management and Budget and
190 revised annually. Eligibility for Medicaid benefits is limited to
191 full payment of Medicare Part B premiums.

192 * * *

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

195 (14) [Deleted]

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

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

211 (17) In accordance with the terms of the federal
212 Personal Responsibility and Work Opportunity Reconciliation Act of
213 1996 (Public Law 104-193), persons who become ineligible for
214 assistance under Title IV-A of the federal Social Security Act, as

215 amended, because of increased income from or hours of employment
216 of the caretaker relative or because of the expiration of the
217 applicable earned income disregards, who were eligible for
218 Medicaid for at least three (3) of the six (6) months preceding
219 the month in which the ineligibility begins, shall be eligible for
220 Medicaid * * * for up to twelve (12) months * * *.

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

230 (19) Disabled workers, whose incomes are above the
231 Medicaid eligibility limits, but below two hundred fifty percent
232 (250%) of the federal poverty level, shall be allowed to purchase
233 Medicaid coverage on a sliding fee scale developed by the Division
234 of Medicaid.

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

240 (21) Women of childbearing age whose family income does
241 not exceed one hundred eighty-five percent (185%) of the federal
242 poverty level. The eligibility of individuals covered under this
243 paragraph (21) shall be determined by the Division of Medicaid,
244 and those individuals determined eligible shall only receive
245 family planning services covered under Section 43-13-117(13) and
246 not any other services covered under Medicaid. However, any
247 individual eligible under this paragraph (21) who is also eligible

248 under any other provision of this section shall receive the
249 benefits to which he or she is entitled under that other
250 provision, in addition to family planning services covered under
251 Section 43-13-117(13).

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

260 (22) Persons who are workers with a potentially severe
261 disability, as determined by the division, shall be allowed to
262 purchase Medicaid coverage. The term "worker with a potentially
263 severe disability" means a person who is at least sixteen (16)
264 years of age but under sixty-five (65) years of age, who has a
265 physical or mental impairment that is reasonably expected to cause
266 the person to become blind or disabled as defined under Section
267 1614(a) of the federal Social Security Act, as amended, if the
268 person does not receive items and services provided under
269 Medicaid.

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

277 *** * ***

278 (23) Children certified by the Mississippi Department
279 of Human Services for whom the state and county <u>departments of</u>
280 human services <u>have</u> custody and financial responsibility who are

281 in foster care on their eighteenth birthday as reported by the
282 Mississippi Department of Human Services shall be certified
283 Medicaid eligible by the Division of Medicaid until their
284 twenty-first birthday.

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

295 * * *

296 **SECTION 2.** Section 43-13-117, Mississippi Code of 1972, is
297 amended as follows:

298 43-13-117. Medicaid as authorized by this article shall
299 include payment of part or all of the costs, at the discretion of
300 the division or its successor, with approval of the Governor, of
301 the following types of care and services rendered to eligible
302 applicants who have been determined to be eligible for that care
303 and services, within the limits of state appropriations and
304 federal matching funds:

305 (1) Inpatient hospital services.

306 (a) The division shall allow thirty (30) days of
307 inpatient hospital care annually for all Medicaid recipients.
308 Precertification of inpatient days must be obtained as required by
309 the division. The division may allow unlimited days in
310 disproportionate hospitals as defined by the division for eligible
311 infants under the age of six (6) years if certified as medically
312 necessary as required by the division.

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

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

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

331 (3) Laboratory and x-ray services.

332 (4) Nursing facility services.

333 (a) The division shall make full payment to
334 nursing facilities for each day, not exceeding thirty (30) days
335 per year, that a patient is absent from the facility on home
336 leave. Payment may be made for the following home leave days in
337 addition to the thirty-day limitation: Christmas, the day before
338 Christmas, the day after Christmas, Thanksgiving, the day before
339 Thanksgiving and the day after Thanksgiving.

340 (b) From and after July 1, 1997, the division
341 shall implement the integrated case-mix payment and quality
342 monitoring system, which includes the fair rental system for
343 property costs and in which recapture of depreciation is
344 eliminated. The division may reduce the payment for hospital
345 leave and therapeutic home leave days to the lower of the case-mix

346 category as computed for the resident on leave using the
347 assessment being utilized for payment at that point in time, or a
348 case-mix score of 1.000 for nursing facilities, and shall compute
349 case-mix scores of residents so that only services provided at the
350 nursing facility are considered in calculating a facility's per
351 diem.

352 During the period between May 1, 2002, and December 1, 2002,
353 the Chairmen of the Public Health and Welfare Committees of the
354 Senate and the House of Representatives may appoint a joint study
355 committee to consider the issue of setting uniform reimbursement
356 rates for nursing facilities. The study committee will consist of
357 the Chairmen of the Public Health and Welfare Committees, three
358 (3) members of the Senate and three (3) members of the House. The
359 study committee shall complete its work in not more than three (3)
360 meetings.

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

364 (d) When a facility of a category that does not
365 require a certificate of need for construction and that could not
366 be eligible for Medicaid reimbursement is constructed to nursing
367 facility specifications for licensure and certification, and the
368 facility is subsequently converted to a nursing facility under a
369 certificate of need that authorizes conversion only and the
370 applicant for the certificate of need was assessed an application
371 review fee based on capital expenditures incurred in constructing
372 the facility, the division shall allow reimbursement for capital
373 expenditures necessary for construction of the facility that were
374 incurred within the twenty-four (24) consecutive calendar months
375 immediately preceding the date that the certificate of need
376 authorizing the conversion was issued, to the same extent that
377 reimbursement would be allowed for construction of a new nursing
378 facility under a certificate of need that authorizes that

379 construction. The reimbursement authorized in this subparagraph
380 (d) may be made only to facilities the construction of which was
381 completed after June 30, 1989. Before the division shall be
382 authorized to make the reimbursement authorized in this
383 subparagraph (d), the division first must have received approval
384 from the Health Care Financing Administration of the United States
385 Department of Health and Human Services of the change in the state
386 Medicaid plan providing for the reimbursement.

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

400 (f) <u>The division shall develop and implement an</u>
401 <u>assessment process for long-term care services.</u>

402 * * *

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

407 (5) Periodic screening and diagnostic services for
408 individuals under age twenty-one (21) years as are needed to
409 identify physical and mental defects and to provide health care
410 treatment and other measures designed to correct or ameliorate
411 defects and physical and mental illness and conditions discovered

412 by the screening services regardless of whether these services are
413 included in the state plan. The division may include in its
414 periodic screening and diagnostic program those discretionary
415 services authorized under the federal regulations adopted to
416 implement Title XIX of the federal Social Security Act, as
417 amended. The division, in obtaining physical therapy services,
418 occupational therapy services, and services for individuals with
419 speech, hearing and language disorders, may enter into a
420 cooperative agreement with the State Department of Education for
421 the provision of those services to handicapped students by public
422 school districts using state funds that are provided from the
423 appropriation to the Department of Education to obtain federal
424 matching funds through the division. The division, in obtaining
425 medical and psychological evaluations for children in the custody
426 of the State Department of Human Services may enter into a
427 cooperative agreement with the State Department of Human Services
428 for the provision of those services using state funds that are
429 provided from the appropriation to the Department of Human
430 Services to obtain federal matching funds through the division.
431 (6) Physician's services. The division shall allow
432 twelve (12) physician visits annually. All fees for physicians'
433 services that are covered only by Medicaid shall be reimbursed at
434 ninety percent (90%) of the rate established on January 1, 1999,
435 and as adjusted each January thereafter, under Medicare (Title
436 XVIII of the Social Security Act, as amended), and which shall in
437 no event be less than seventy percent (70%) of the rate
438 established on January 1, 1994. All fees for physicians' services
439 that are covered by both Medicare and Medicaid shall be reimbursed
440 at ten percent (10%) of the adjusted Medicare payment established
441 on January 1, 1999, and as adjusted each January thereafter, under
442 Medicare (Title XVIII of the Social Security Act, as amended), and
443 which shall in no event be less than seventy percent (70%) of the
444 adjusted Medicare payment established on January 1, 1994.

445 (7) (a) Home health services for eligible persons, not
446 to exceed in cost the prevailing cost of nursing facility
447 services, not to exceed sixty (60) visits per year. All home
448 health visits must be precertified as required by the division.
449 (b) Repealed.
450 (8) Emergency medical transportation services. On
451 January 1, 1994, emergency medical transportation services shall
452 be reimbursed at seventy percent (70%) of the rate established
453 under Medicare (Title XVIII of the Social Security Act, as
454 amended). "Emergency medical transportation services" shall mean,
455 but shall not be limited to, the following services by a properly
456 permitted ambulance operated by a properly licensed provider in
457 accordance with the Emergency Medical Services Act of 1974
458 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
459 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
460 (vi) disposable supplies, (vii) similar services.
461 (9) (a) Legend and other drugs as may be determined by
462 the division. The division shall <u>contract for full scope pharmacy</u>
463 <u>benefit management services and shall implement a preferred drug</u>
464 <u>list (PDL), a mail-order option and supplemental rebates and, if</u>
465 <u>feasible, shall enter into the contract(s) in conjunction with the</u>
466 <u>State and School Employees Health Insurance Plan for this and</u>
467 <u>other states in order to take advantage of coalition buying.</u> The
468 division may implement a program of prior approval for drugs to
469 the extent permitted by law. The division shall allow seven (7)
470 prescriptions per month for each noninstitutionalized Medicaid
471 recipient *** * ***. The division shall not reimburse for any portion
472 of a prescription that exceeds a thirty-four-day supply of the
473 drug based on the daily dosage.
474 *** * ***
475 The division shall develop and implement a program of payment
476 for additional pharmacist services, with payment to be based on

477 demonstrated savings, but in no case shall the total payment
478 exceed twice the amount of the dispensing fee.
479 All claims for drugs for dually eligible Medicare/Medicaid
480 beneficiaries that are paid for by Medicare must be submitted to
481 Medicare for payment before they may be processed by the
482 division's on-line payment system.
483 The division shall develop a pharmacy policy in which drugs
484 in tamper-resistant packaging that are prescribed for a resident
485 of a nursing facility but are not dispensed to the resident shall
486 be returned to the pharmacy and not billed to Medicaid, in
487 accordance with guidelines of the State Board of Pharmacy.
488 (b) *** * *** Payment by the division for covered
489 multiple source drugs shall be limited to the lower of the upper
490 limits established and published by the Centers for Medicare and
491 Medicaid Services (CMS) plus a dispensing fee, or the estimated
492 acquisition cost (EAC) plus a dispensing fee, or the providers'
493 usual and customary charge to the general public. *** * ***
494 Payment for other covered drugs, other than multiple source
495 drugs with CMS upper limits, shall not exceed the lower of the
496 estimated acquisition cost plus a dispensing fee or the providers'
497 usual and customary charge to the general public.
498 Payment for nonlegend or over-the-counter drugs covered <u>by</u>
499 the <u>division</u> shall be reimbursed at the lower of the division's
500 estimated shelf price or the providers' usual and customary charge
501 to the general public. *** * ***
502 The dispensing fee for each new or refill prescription<u>,</u>
503 <u>including nonlegend or over-the-counter drugs covered by the</u>
504 <u>division,</u> shall be Three Dollars and Ninety-one Cents ($3.91).
505 The Medicaid provider shall not prescribe, the Medicaid
506 pharmacy shall not bill, and the division shall not reimburse for
507 name brand drugs if there are equally effective generic
508 equivalents available and if the generic equivalents are the least
509 expensive.

510 * * *

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

514 * * *

515 (10) Dental care that is an adjunct to treatment of an
516 acute medical or surgical condition; services of oral surgeons and
517 dentists in connection with surgery related to the jaw or any
518 structure contiguous to the jaw or the reduction of any fracture
519 of the jaw or any facial bone; and emergency dental extractions
520 and treatment related thereto. On July 1, 1999, all fees for
521 dental care and surgery under authority of this paragraph (10)
522 shall be increased to one hundred sixty percent (160%) of the
523 amount of the reimbursement rate that was in effect on June 30,
524 1999. It is the intent of the Legislature to encourage more
525 dentists to participate in the Medicaid program.

526 (11) Eyeglasses for all Medicaid beneficiaries who have
527 (a) had surgery on the eyeball or ocular muscle that results in a
528 vision change for which eyeglasses or a change in eyeglasses is
529 medically indicated within six (6) months of the surgery and is in
530 accordance with policies established by the division, or (b) one
531 (1) pair every five (5) years and in accordance with policies
532 established by the division. In either instance, the eyeglasses
533 must be prescribed by a physician skilled in diseases of the eye
534 or an optometrist, whichever the beneficiary may select.

535 (12) Intermediate care facility services.

536 (a) The division shall make full payment to all
537 intermediate care facilities for the mentally retarded for each
538 day, not exceeding sixty 60 days per year, that a patient is
539 absent from the facility on home leave. Payment may be made for
540 the following home leave days in addition to the sixty-day
541 limitation: Christmas, the day before Christmas, the day after

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

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

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

550 (14) Clinic services. Such diagnostic, preventive,
551 therapeutic, rehabilitative or palliative services furnished to an
552 outpatient by or under the supervision of a physician or dentist
553 in a facility that is not a part of a hospital but that is
554 organized and operated to provide medical care to outpatients.
555 Clinic services shall include any services reimbursed as
556 outpatient hospital services that may be rendered in such a
557 facility, including those that become so after July 1, 1991. On
558 July 1, 1999, all fees for physicians' services reimbursed under
559 authority of this paragraph (14) shall be reimbursed at ninety
560 percent (90%) of the rate established on January 1, 1999, and as
561 adjusted each January thereafter, under Medicare (Title XVIII of
562 the Social Security Act, as amended), and which shall in no event
563 be less than seventy percent (70%) of the rate established on
564 January 1, 1994. All fees for physicians' services that are
565 covered by both Medicare and Medicaid shall be reimbursed at ten
566 percent (10%) of the adjusted Medicare payment established on
567 January 1, 1999, and as adjusted each January thereafter, under
568 Medicare (Title XVIII of the Social Security Act, as amended), and
569 which shall in no event be less than seventy percent (70%) of the
570 adjusted Medicare payment established on January 1, 1994. On July
571 1, 1999, all fees for dentists' services reimbursed under
572 authority of this paragraph (14) shall be increased to one hundred
573 sixty percent (160%) of the amount of the reimbursement rate that
574 was in effect on June 30, 1999.

575 (15) Home- and community-based services <u>for the elderly</u>
576 <u>and disabled</u>, as provided under Title XIX of the federal Social
577 Security Act, as amended, under waivers, subject to the
578 availability of funds specifically appropriated therefor by the
579 Legislature. *** * ***
580 (16) Mental health services. Approved therapeutic and
581 case management services (a) provided by an approved regional
582 mental health/retardation center established under Sections
583 41-19-31 through 41-19-39, or by another community mental health
584 service provider meeting the requirements of the Department of
585 Mental Health to be an approved mental health/retardation center
586 if determined necessary by the Department of Mental Health, using
587 state funds that are provided from the appropriation to the State
588 Department of Mental Health and/or funds transferred to the
589 department by a political subdivision or instrumentality of the
590 state and used to match federal funds under a cooperative
591 agreement between the division and the department, or (b) provided
592 by a facility that is certified by the State Department of Mental
593 Health to provide therapeutic and case management services, to be
594 reimbursed on a fee for service basis, or (c) provided in the
595 community by a facility or program operated by the Department of
596 Mental Health. Any such services provided by a facility described
597 in <u>sub</u>paragraph (b) must have the prior approval of the division
598 to be reimbursable under this section. After June 30, 1997,
599 mental health services provided by regional mental
600 health/retardation centers established under Sections 41-19-31
601 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
602 and/or their subsidiaries and divisions, or by psychiatric
603 residential treatment facilities as defined in Section 43-11-1, or
604 by another community mental health service provider meeting the
605 requirements of the Department of Mental Health to be an approved
606 mental health/retardation center if determined necessary by the
607 Department of Mental Health, shall not be included in or provided

608 under any capitated managed care pilot program provided for under
609 paragraph (24) of this section.
610 (17) Durable medical equipment services and medical
611 supplies. Precertification of durable medical equipment and
612 medical supplies must be obtained as required by the division.
613 The Division of Medicaid may require durable medical equipment
614 providers to obtain a surety bond in the amount and to the
615 specifications as established by the Balanced Budget Act of 1997.
616 (18) (a) Notwithstanding any other provision of this
617 section to the contrary, the division shall make additional
618 reimbursement to hospitals that serve a disproportionate share of
619 low-income patients and that meet the federal requirements for
620 those payments as provided in Section 1923 of the federal Social
621 Security Act and any applicable regulations. However, from and
622 after January 1, 1999, no public hospital shall participate in the
623 Medicaid disproportionate share program unless the public hospital
624 participates in an intergovernmental transfer program as provided
625 in Section 1903 of the federal Social Security Act and any
626 applicable regulations. Administration and support for
627 participating hospitals shall be provided by the Mississippi
628 Hospital Association.
629 (b) The division shall establish a Medicare Upper
630 Payment Limits Program, as defined in Section 1902(a)(30) of the
631 federal Social Security Act and any applicable federal
632 regulations, for hospitals, and may establish a Medicare Upper
633 Payments Limits Program for nursing facilities. The division
634 shall assess each hospital and, if the program is established for
635 nursing facilities, shall assess each nursing facility, for the
636 sole purpose of financing the state portion of the Medicare Upper
637 Payment Limits Program. This assessment shall be based on
638 Medicaid utilization, or other appropriate method consistent with
639 federal regulations, and will remain in effect as long as the
640 state participates in the Medicare Upper Payment Limits Program.

641 The division shall make additional reimbursement to hospitals and,
642 if the program is established for nursing facilities, shall make
643 additional reimbursement to nursing facilities, for the Medicare
644 Upper Payment Limits, as defined in Section 1902(a)(30) of the
645 federal Social Security Act and any applicable federal
646 regulations. This subparagraph (b) shall stand repealed from and
647 after July 1, 2005.
648 (c) The division shall contract with the
649 Mississippi Hospital Association to provide administrative support
650 for the operation of the disproportionate share hospital program
651 and the Medicare Upper Payment Limits Program. This subparagraph
652 (c) shall stand repealed from and after July 1, 2005.
653 (19) (a) Perinatal risk management services. The
654 division shall promulgate regulations to be effective from and
655 after October 1, 1988, to establish a comprehensive perinatal
656 system for risk assessment of all pregnant and infant Medicaid
657 recipients and for management, education and follow-up for those
658 who are determined to be at risk. Services to be performed
659 include case management, nutrition assessment/counseling,
660 psychosocial assessment/counseling and health education. The
661 division shall set reimbursement rates for providers in
662 conjunction with the State Department of Health.
663 (b) Early intervention system services. The
664 division shall cooperate with the State Department of Health,
665 acting as lead agency, in the development and implementation of a
666 statewide system of delivery of early intervention services, under
667 Part C of the Individuals with Disabilities Education Act (IDEA).
668 The State Department of Health shall certify annually in writing
669 to the executive director of the division the dollar amount of
670 state early intervention funds available that will be utilized as
671 a certified match for Medicaid matching funds. Those funds then
672 shall be used to provide expanded targeted case management
673 services for Medicaid eligible children with special needs who are

674 eligible for the state's early intervention system.
675 Qualifications for persons providing service coordination shall be
676 determined by the State Department of Health and the Division of
677 Medicaid.
678 (20) Home- and community-based services for physically
679 disabled approved services as allowed by a waiver from the United
680 States Department of Health and Human Services for home- and
681 community-based services for physically disabled people using
682 state funds that are provided from the appropriation to the State
683 Department of Rehabilitation Services and used to match federal
684 funds under a cooperative agreement between the division and the
685 department, provided that funds for these services are
686 specifically appropriated to the Department of Rehabilitation
687 Services.
688 (21) Nurse practitioner services. Services furnished
689 by a registered nurse who is licensed and certified by the
690 Mississippi Board of Nursing as a nurse practitioner, including,
691 but not limited to, nurse anesthetists, nurse midwives, family
692 nurse practitioners, family planning nurse practitioners,
693 pediatric nurse practitioners, obstetrics-gynecology nurse
694 practitioners and neonatal nurse practitioners, under regulations
695 adopted by the division. Reimbursement for those services shall
696 not exceed ninety percent (90%) of the reimbursement rate for
697 comparable services rendered by a physician.
698 (22) Ambulatory services delivered in federally
699 qualified health centers, rural health centers and clinics of the
700 local health departments of the State Department of Health for
701 individuals eligible for Medicaid under this article based on
702 reasonable costs as determined by the division.
703 (23) Inpatient psychiatric services. Inpatient
704 psychiatric services to be determined by the division for
705 recipients under age twenty-one (21) that are provided under the
706 direction of a physician in an inpatient program in a licensed

707 acute care psychiatric facility or in a licensed psychiatric
708 residential treatment facility, before the recipient reaches age
709 twenty-one (21) or, if the recipient was receiving the services
710 immediately before he reached age twenty-one (21), before the
711 earlier of the date he no longer requires the services or the date
712 he reaches age twenty-two (22), as provided by federal
713 regulations. Precertification of inpatient days and residential
714 treatment days must be obtained as required by the division.

715 (24) [Deleted]

716 (25) [Deleted]

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

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

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

735 (29) The Division of Medicaid may apply for a waiver
736 from the Department of Health and Human Services for home- and
737 community-based services for developmentally disabled people using
738 state funds that are provided from the appropriation to the State
739 Department of Mental Health and/or funds transferred to the

740 department by a political subdivision or instrumentality of the
741 state and used to match federal funds under a cooperative
742 agreement between the division and the department, provided that
743 funds for these services are specifically appropriated to the
744 Department of Mental Health and/or transferred to the department
745 by a political subdivision or instrumentality of the state.
746 (30) Pediatric skilled nursing services for eligible
747 persons under twenty-one (21) years of age.
748 (31) Targeted case management services for children
749 with special needs, under waivers from the United States
750 Department of Health and Human Services, using state funds that
751 are provided from the appropriation to the Mississippi Department
752 of Human Services and used to match federal funds under a
753 cooperative agreement between the division and the department.
754 (32) Care and services provided in Christian Science
755 Sanatoria listed and certified by the Commission for Accreditation
756 of Christian Science Nursing Organizations/Facilities, Inc.,
757 rendered in connection with treatment by prayer or spiritual means
758 to the extent that those services are subject to reimbursement
759 under Section 1903 of the Social Security Act.
760 (33) Podiatrist services.
761 (34) Assisted living services as provided through home-
762 and community-based services under Title XIX of the Social
763 Security Act, as amended, subject to the availability of funds
764 specifically appropriated therefor by the Legislature.
765 (35) Services and activities authorized in Sections
766 43-27-101 and 43-27-103, using state funds that are provided from
767 the appropriation to the State Department of Human Services and
768 used to match federal funds under a cooperative agreement between
769 the division and the department.
770 (36) Nonemergency transportation services for
771 Medicaid-eligible persons, to be provided by the Division of
772 Medicaid. The division may contract with additional entities to

773 administer nonemergency transportation services as it deems
774 necessary. All providers shall have a valid driver's license,
775 vehicle inspection sticker, valid vehicle license tags and a
776 standard liability insurance policy covering the vehicle. The
777 division may pay providers a flat fee based on mileage tiers, or
778 in the alternative, may reimburse on actual miles traveled. The
779 division may apply to the federal Centers for Medicare and
780 Medicaid Services (CMS) for a worker to draw federal matching
781 funds for nonemergency transportation services as a covered
782 service instead of an administrative cost.
783 (37) [Deleted]
784 (38) Chiropractic services. A chiropractor's manual
785 manipulation of the spine to correct a subluxation, if x-ray
786 demonstrates that a subluxation exists and if the subluxation has
787 resulted in a neuromusculoskeletal condition for which
788 manipulation is appropriate treatment, and related spinal x-rays
789 performed to document these conditions. Reimbursement for
790 chiropractic services shall not exceed Seven Hundred Dollars
791 ($700.00) per year per beneficiary.
792 (39) Dually eligible Medicare/Medicaid beneficiaries.
793 The division shall pay the Medicare deductible and * * *
794 coinsurance amounts for services available under Medicare, as
795 determined by the division.
796 (40) [Deleted]
797 (41) Services provided by the State Department of
798 Rehabilitation Services for the care and rehabilitation of persons
799 with spinal cord injuries or traumatic brain injuries, as allowed
800 under waivers from the United States Department of Health and
801 Human Services, using up to seventy-five percent (75%) of the
802 funds that are appropriated to the Department of Rehabilitation
803 Services from the Spinal Cord and Head Injury Trust Fund
804 established under Section 37-33-261 and used to match federal

805 funds under a cooperative agreement between the division and the
806 department.
807 (42) Notwithstanding any other provision in this
808 article to the contrary, the division may develop a population
809 health management program for women and children health services
810 through the age of one (1) year. This program is primarily for
811 obstetrical care associated with low birth weight and pre-term
812 babies. The division may apply to the federal Centers for
813 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
814 any other waivers that may enhance the program. In order to
815 effect cost savings, the division may develop a revised payment
816 methodology that may include at-risk capitated payments, and may
817 require member participation in accordance with the terms and
818 conditions of an approved federal waiver.
819 (43) The division shall provide reimbursement,
820 according to a payment schedule developed by the division, for
821 smoking cessation medications for pregnant women during their
822 pregnancy and other Medicaid-eligible women who are of
823 child-bearing age.
824 (44) Nursing facility services for the severely
825 disabled.
826 (a) Severe disabilities include, but are not
827 limited to, spinal cord injuries, closed head injuries and
828 ventilator dependent patients.
829 (b) Those services must be provided in a long-term
830 care nursing facility dedicated to the care and treatment of
831 persons with severe disabilities, and shall be reimbursed as a
832 separate category of nursing facilities.
833 (45) Physician assistant services. Services furnished
834 by a physician assistant who is licensed by the State Board of
835 Medical Licensure and is practicing with physician supervision
836 under regulations adopted by the board, under regulations adopted
837 by the division. Reimbursement for those services shall not

838 exceed ninety percent (90%) of the reimbursement rate for
839 comparable services rendered by a physician.
840 (46) The division shall make application to the federal
841 Centers for Medicare and Medicaid Services (CMS) for a waiver to
842 develop and provide services for children with serious emotional
843 disturbances as defined in Section 43-14-1(1), which may include
844 home- and community-based services, case management services or
845 managed care services through mental health providers certified by
846 the Department of Mental Health. The division may implement and
847 provide services under this waivered program only if funds for
848 these services are specifically appropriated for this purpose by
849 the Legislature, or if funds are voluntarily provided by affected
850 agencies.
851 (47) Notwithstanding any other provision in this
852 article to the contrary, the division *** * *** shall develop and
853 implement disease management programs *** * ***.
854 (48) Pediatric long-term acute care hospital services.
855 (a) Pediatric long-term acute care hospital
856 services means services provided to eligible persons under
857 twenty-one (21) years of age by a freestanding Medicare-certified
858 hospital that has an average length of inpatient stay greater than
859 twenty-five (25) days and that is primarily engaged in providing
860 chronic or long-term medical care to persons under twenty-one (21)
861 years of age.
862 (b) The services under this paragraph (48) shall
863 be reimbursed as a separate category of hospital services.
864 (49) The division shall establish copayments for all
865 Medicaid services for which copayments are allowable under federal
866 law or regulation, except for nonemergency transportation
867 services, and shall set the amount of the copayment for each of
868 those services at the maximum amount allowable under federal law
869 or regulation.

870 Notwithstanding any other provision of this article to the
871 contrary, the division shall reduce the rate of reimbursement to
872 providers for any service provided under this section by five
873 percent (5%) of the allowed amount for that service. However, the
874 reduction in the reimbursement rates required by this paragraph
875 shall not apply to inpatient hospital services, nursing facility
876 services, intermediate care facility services, psychiatric
877 residential treatment facility services, pharmacy services
878 provided under paragraph (9) of this section, or any service
879 provided by the University of Mississippi Medical Center or a
880 state agency, a state facility or a public agency that either
881 provides its own state match through intergovernmental transfer or
882 certification of funds to the division, or a service for which the
883 federal government sets the reimbursement methodology and rate.
884 In addition, the reduction in the reimbursement rates required by
885 this paragraph shall not apply to *** * *** home- and community-based
886 services programs. The division may remove the five percent (5%)
887 reduction in reimbursement for those providers who participate in
888 the division's emergency room redirection program and achieve the
889 performance measures and reduction of costs required of that
890 program.
891 Notwithstanding any provision of this article, except as
892 authorized in the following paragraph and in Section 43-13-139,
893 neither (a) the limitations on quantity or frequency of use of or
894 the fees or charges for any of the care or services available to
895 recipients under this section, nor (b) the payments or rates of
896 reimbursement to providers rendering care or services authorized
897 under this section to recipients, may be increased, decreased or
898 otherwise changed from the levels in effect on July 1, 1999,
899 unless they are authorized by an amendment to this section by the
900 Legislature. However, the restriction in this paragraph shall not
901 prevent the division from changing the payments or rates of
902 reimbursement to providers without an amendment to this section

903 whenever those changes are required by federal law or regulation,
904 or whenever those changes are necessary to correct administrative
905 errors or omissions in calculating those payments or rates of
906 reimbursement.

907 Notwithstanding any provision of this article, no new groups
908 or categories of recipients and new types of care and services may
909 be added without enabling legislation from the Mississippi
910 Legislature, except that the division may authorize those changes
911 without enabling legislation when the addition of recipients or
912 services is ordered by a court of proper authority. The executive
913 director shall keep the Governor advised on a timely basis of the
914 funds available for expenditure and the projected expenditures.
915 If current or projected expenditures of the division can be
916 reasonably anticipated to exceed the amounts appropriated for any
917 fiscal year, the Governor, after consultation with the executive
918 director, shall discontinue any or all of the payment of the types
919 of care and services as provided in this section that are deemed
920 to be optional services under Title XIX of the federal Social
921 Security Act, as amended, for any period necessary to not exceed
922 appropriated funds, and when necessary shall institute any other
923 cost containment measures on any program or programs authorized
924 under the article to the extent allowed under the federal law
925 governing that program or programs, it being the intent of the
926 Legislature that expenditures during any fiscal year shall not
927 exceed the amounts appropriated for that fiscal year.

928 Notwithstanding any other provision of this article, it shall
929 be the duty of each nursing facility, intermediate care facility
930 for the mentally retarded, psychiatric residential treatment
931 facility, and nursing facility for the severely disabled that is
932 participating in the Medicaid program to keep and maintain books,
933 documents and other records as prescribed by the Division of
934 Medicaid in substantiation of its cost reports for a period of
935 three (3) years after the date of submission to the Division of

936 Medicaid of an original cost report, or three (3) years after the
937 date of submission to the Division of Medicaid of an amended cost
938 report.

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

940 **SECTION 3.** Section 43-13-107, Mississippi Code of 1972, is
941 amended as follows:

942 43-13-107. (1) The Division of Medicaid is created in the
943 Office of the Governor and established to administer this article
944 and perform such other duties as are prescribed by law.

945 (2) (a) The Governor shall appoint a full-time executive
946 director, with the advice and consent of the Senate, who shall be
947 either (i) a physician with administrative experience in a medical
948 care or health program, or (ii) a person holding a graduate degree
949 in medical care administration, public health, hospital
950 administration, or the equivalent, or (iii) a person holding a
951 bachelor's degree in business administration or hospital
952 administration, with at least ten (10) years' experience in
953 management-level administration of Medicaid programs, and who
954 shall serve at the will and pleasure of the Governor. The
955 executive director shall be the official secretary and legal
956 custodian of the records of the division; shall be the agent of
957 the division for the purpose of receiving all service of process,
958 summons and notices directed to the division; and shall perform
959 such other duties as the Governor may prescribe from time to time.

960 (b) The executive director, with the approval of the
961 Governor and subject to the rules and regulations of the State
962 Personnel Board, shall employ such professional, administrative,
963 stenographic, secretarial, clerical and technical assistance as
964 may be necessary to perform the duties required in administering
965 this article and fix the compensation therefor, all in accordance
966 with a state merit system meeting federal requirements when the
967 salary of the executive director is not set by law, that salary
968 shall be set by the State Personnel Board. No employees of the

969 Division of Medicaid shall be considered to be staff members of
970 the immediate Office of the Governor; however, the provisions of
971 Section 25-9-107(c)(xv) shall apply to the executive director and
972 other administrative heads of the division.

973 (3) (a) There is established a Medical Care Advisory
974 Committee, which shall be the committee that is required by
975 federal regulation to advise the Division of Medicaid about health
976 and medical care services.

977 (b) The advisory committee shall consist of not less
978 than eleven (11) members, as follows:

979 (i) The Governor shall appoint five (5) members,
980 one (1) from each congressional district as presently constituted;

981 (ii) The Lieutenant Governor shall appoint three
982 (3) members, one (1) from each Supreme Court district;

983 (iii) The Speaker of the House of Representatives
984 shall appoint three (3) members, one (1) from each Supreme Court
985 district.

986 All members appointed under this paragraph shall either be
987 health care providers or consumers of health care services. One
988 (1) member appointed by each of the appointing authorities shall
989 be a board certified physician.

990 (c) The respective chairmen of the House Public Health
991 and Welfare Committee, the House Appropriations Committee, the
992 Senate Public Health and Welfare Committee and the Senate
993 Appropriations Committee, or their designees, one (1) member of
994 the State Senate appointed by the Lieutenant Governor and one (1)
995 member of the House of Representatives appointed by the Speaker of
996 the House, shall serve as ex officio nonvoting members of the
997 advisory committee.

998 (d) In addition to the committee members required by
999 paragraph (b), the advisory committee shall consist of such other
1000 members as are necessary to meet the requirements of the federal

1001 regulation applicable to the advisory committee, who shall be
1002 appointed as provided in the federal regulation.
1003 (e) The chairmanship of the advisory committee shall
1004 alternate for twelve-month periods between the chairmen of the
1005 House and Senate Public Health and Welfare Committees, with the
1006 Chairman of the House Public Health and Welfare Committee serving
1007 as the first chairman.
1008 (f) The members of the advisory committee specified in
1009 paragraph (b) shall serve for terms that are concurrent with the
1010 terms of members of the Legislature, and any member appointed
1011 under paragraph (b) may be reappointed to the advisory committee.
1012 The members of the advisory committee specified in paragraph (b)
1013 shall serve without compensation, but shall receive reimbursement
1014 to defray actual expenses incurred in the performance of committee
1015 business as authorized by law. Legislators shall receive per diem
1016 and expenses which may be paid from the contingent expense funds
1017 of their respective houses in the same amounts as provided for
1018 committee meetings when the Legislature is not in session.
1019 (g) The advisory committee shall meet not less than
1020 quarterly, and advisory committee members shall be furnished
1021 written notice of the meetings at least ten (10) days before the
1022 date of the meeting.
1023 (h) The executive director shall submit to the advisory
1024 committee all amendments, modifications and changes to the state
1025 plan for the operation of the Medicaid program, for review by the
1026 advisory committee before the amendments, modifications or changes
1027 may be implemented by the division.
1028 (i) The advisory committee, among its duties and
1029 responsibilities, shall:
1030 (i) Advise the division with respect to
1031 amendments, modifications and changes to the state plan for the
1032 operation of the Medicaid program;

1033 (ii) Advise the division with respect to issues
1034 concerning receipt and disbursement of funds and eligibility for
1035 Medicaid;
1036 (iii) Advise the division with respect to
1037 determining the quantity, quality and extent of medical care
1038 provided under this article;
1039 (iv) Communicate the views of the medical care
1040 professions to the division and communicate the views of the
1041 division to the medical care professions;
1042 (v) Gather information on reasons that medical
1043 care providers do not participate in the Medicaid program and
1044 changes that could be made in the program to encourage more
1045 providers to participate in the Medicaid program, and advise the
1046 division with respect to encouraging physicians and other medical
1047 care providers to participate in the Medicaid program;
1048 (vi) Provide a written report on or before
1049 November 30 of each year to the Governor, Lieutenant Governor and
1050 Speaker of the House of Representatives.
1051 (4) (a) There is established a Drug Use Review Board, which
1052 shall be the board that is required by federal law to:
1053 (i) Review and initiate retrospective drug use,
1054 review including ongoing periodic examination of claims data and
1055 other records in order to identify patterns of fraud, abuse, gross
1056 overuse, or inappropriate or medically unnecessary care, among
1057 physicians, pharmacists and individuals receiving Medicaid
1058 benefits or associated with specific drugs or groups of drugs.
1059 (ii) Review and initiate ongoing interventions for
1060 physicians and pharmacists, targeted toward therapy problems or
1061 individuals identified in the course of retrospective drug use
1062 reviews.
1063 (iii) On an ongoing basis, assess data on drug use
1064 against explicit predetermined standards using the compendia and
1065 literature set forth in federal law and regulations.

1066 (b) The board shall consist of not less than twelve
1067 (12) members appointed by the Governor, or his designee.
1068 (c) The board shall meet at least quarterly, and board
1069 members shall be furnished written notice of the meetings at least
1070 ten (10) days before the date of the meeting.
1071 (d) The board meetings shall be open to the public,
1072 members of the press, legislators and consumers. Additionally,
1073 all documents provided to board members shall be available to
1074 members of the Legislature in the same manner, and shall be made
1075 available to others for a reasonable fee for copying. However,
1076 patient confidentiality and provider confidentiality shall be
1077 protected by blinding patient names and provider names with
1078 numerical or other anonymous identifiers. The board meetings
1079 shall be subject to the Open Meetings Act (Section 25-41-1 et
1080 seq.). Board meetings conducted in violation of this section
1081 shall be deemed unlawful.
1082 (5) (a) There is established a Pharmacy and Therapeutics
1083 Committee, which shall be appointed by the Governor, or his
1084 designee.
1085 (b) The committee shall meet at least quarterly, and
1086 committee members shall be furnished written notice of the
1087 meetings at least ten (10) days before the date of the meeting.
1088 (c) The committee meetings shall be open to the public,
1089 members of the press, legislators and consumers. Additionally,
1090 all documents provided to committee members shall be available to
1091 members of the Legislature in the same manner, and shall be made
1092 available to others for a reasonable fee for copying. However,
1093 patient confidentiality and provider confidentiality shall be
1094 protected by blinding patient names and provider names with
1095 numerical or other anonymous identifiers. The committee meetings
1096 shall be subject to the Open Meetings Act (Section 25-41-1 et
1097 seq.). Committee meetings conducted in violation of this section
1098 shall be deemed unlawful.

1099 (d) After a thirty-day public notice, the executive
1100 director or his or her designee shall present the division's
1101 recommendation regarding prior approval for a therapeutic class of
1102 drugs to the committee. However, in circumstances where the
1103 division deems it necessary for the health and safety of Medicaid
1104 beneficiaries, the division may present to the committee its
1105 recommendations regarding a particular drug without a thirty-day
1106 public notice. In making the presentation, the division shall
1107 state to the committee the circumstances that precipitate the need
1108 for the committee to review the status of a particular drug
1109 without a thirty-day public notice. The committee may determine
1110 whether or not to review the particular drug under the
1111 circumstances stated by the division without a thirty-day public
1112 notice. If the committee determines to review the status of the
1113 particular drug, it shall make its recommendations to the
1114 division, after which the division shall file the recommendations
1115 for a thirty-day public comment under the provisions of Section
1116 25-43-7(1).
1117 (e) Upon reviewing the information and recommendations,
1118 the committee shall forward a written recommendation approved by a
1119 majority of the committee to the executive director or his or her
1120 designee. The decisions of the committee regarding any
1121 limitations to be imposed on any drug or its use for a specified
1122 indication shall be based on sound clinical evidence found in
1123 labeling, drug compendia, and peer reviewed clinical literature
1124 pertaining to use of the drug in the relevant population.
1125 (f) Upon reviewing and considering all recommendations
1126 including recommendation of the committee, comments, and data, the
1127 executive director shall make a final determination whether to
1128 require prior approval of a therapeutic class of drugs, or modify
1129 existing prior approval requirements for a therapeutic class of
1130 drugs.

1131 (g) At least thirty (30) days before the executive
1132 director implements new or amended prior authorization decisions,
1133 written notice of the executive director's decision shall be
1134 provided to all prescribing Medicaid providers, all Medicaid
1135 enrolled pharmacies, and any other party who has requested the
1136 notification. However, notice given under Section 25-43-7(1) will
1137 substitute for and meet the requirement for notice under this
1138 subsection.

1139 (6) This section shall stand repealed on July 1, 2004.

1140 **SECTION 4.** Section 43-13-122, Mississippi Code of 1972, is
1141 amended as follows:

1142 43-13-122. (1) The division may apply to the federal
1143 Centers for Medicare and Medicaid Services (CMS) of the United
1144 States Department of Health and Human Services for waivers and
1145 research and demonstration grants *** * * ***.

1146 (2) The division may accept and expend any grants, donations
1147 or contributions from any public or private organization, together
1148 with any additional federal matching funds that may accrue and
1149 including, but not limited to, one hundred percent (100%) federal
1150 grant funds or funds from any governmental entity or
1151 instrumentality thereof in furthering the purposes and objectives
1152 of the Mississippi Medicaid program, provided that those receipts
1153 and expenditures are reported and otherwise handled in accordance
1154 with the General Fund Stabilization Act. The Department of
1155 Finance and Administration may transfer monies to the division
1156 from special funds in the State Treasury in amounts not exceeding
1157 the amounts authorized in the appropriation to the division.

1158 **SECTION 5.** Section 43-13-145, Mississippi Code of 1972, is
1159 amended as follows:

1160 43-13-145. (1) (a) Upon each nursing facility and each
1161 intermediate care facility for the mentally retarded licensed by
1162 the State of Mississippi, there is levied an assessment in the
1163 amount of Four Dollars ($4.00) per day for each licensed and/or

1164 certified bed of the facility. The division may apply for a
1165 waiver from the United States Secretary of Health and Human
1166 Services to exempt nonprofit, public, charitable or religious
1167 facilities from the assessment levied under this subsection, and
1168 if a waiver is granted, those facilities shall be exempt from any
1169 assessment levied under this subsection after the date that the
1170 division receives notice that the waiver has been granted.
1171 (b) A nursing facility or intermediate care facility
1172 for the mentally retarded is exempt from the assessment levied
1173 under this subsection if the facility is operated under the
1174 direction and control of:
1175 (i) The United States Veterans Administration or
1176 other agency or department of the United States government;
1177 (ii) The State Veterans Affairs Board;
1178 (iii) The University of Mississippi Medical
1179 Center; or
1180 (iv) A state agency or a state facility that
1181 either provides its own state match through intergovernmental
1182 transfer or certification of funds to the division.
1183 (2) (a) Upon each psychiatric residential treatment
1184 facility licensed by the State of Mississippi, there is levied an
1185 assessment in the amount of Three Dollars ($3.00) per day for each
1186 licensed and/or certified bed of the facility.
1187 (b) A psychiatric residential treatment facility is
1188 exempt from the assessment levied under this subsection if the
1189 facility is operated under the direction and control of:
1190 (i) The United States Veterans Administration or
1191 other agency or department of the United States government;
1192 (ii) The University of Mississippi Medical Center;
1193 (iii) A state agency or a state facility that
1194 either provides its own state match through intergovernmental
1195 transfer or certification of funds to the division.

1196 (3) (a) Upon each hospital licensed by the State of
1197 Mississippi, there is levied an assessment in the amount of One
1198 Dollar and Fifty Cents ($1.50) per day for each licensed inpatient
1199 acute care bed of the hospital.
1200 (b) A hospital is exempt from the assessment levied
1201 under this subsection if the hospital is operated under the
1202 direction and control of:
1203 (i) The United States Veterans Administration or
1204 other agency or department of the United States government;
1205 (ii) The University of Mississippi Medical Center;
1206 or
1207 (iii) A state agency or a state facility that
1208 either provides its own state match through intergovernmental
1209 transfer or certification of funds to the division.
1210 (4) Each health care facility that is subject to the
1211 provisions of this section shall keep and preserve such suitable
1212 books and records as may be necessary to determine the amount of
1213 assessment for which it is liable under this section. The books
1214 and records shall be kept and preserved for a period of not less
1215 than five (5) years, and those books and records shall be open for
1216 examination during business hours by the division, the State Tax
1217 Commission, the Office of the Attorney General and the State
1218 Department of Health.
1219 (5) The assessment levied under this section shall be
1220 collected by the division each month beginning on April 12, 2002.
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 any
1284 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) From and after the effective date of House Bill No.
1363 ____, 2003 Regular Session, the State Department of Health shall
1364 not issue a certificate of need to any person for the new
1365 construction of, addition to, expansion of or conversion to any
1366 skilled or intermediate care nursing facility beds or services.
1367 Before the effective date of House Bill No. ____, 2003 Regular
1368 Session, the State Department of Health shall not grant approval
1369 for or issue a certificate of need to any person proposing the new
1370 construction of, addition to, or expansion of any health care
1371 facility defined in subparagraphs (iv) (skilled nursing facility)
1372 and (vi) (intermediate care facility) of Section 41-7-173(h) or
1373 the conversion of vacant hospital beds to provide skilled or
1374 intermediate nursing home care, except as hereinafter authorized:
1375 (a) The department may issue a certificate of need to
1376 any person proposing the new construction of any health care
1377 facility defined in subparagraphs (iv) and (vi) of Section
1378 41-7-173(h) as part of a life care retirement facility, in any
1379 county bordering on the Gulf of Mexico in which is located a
1380 National Aeronautics and Space Administration facility, not to
1381 exceed forty (40) beds. From and after July 1, 1999, there shall
1382 be no prohibition or restrictions on participation in the Medicaid
1383 program (Section 43-13-101 et seq.) for the beds in the health
1384 care facility that were authorized under this paragraph (a).
1385 (b) The department may issue certificates of need in
1386 Harrison County to provide skilled nursing home care for
1387 Alzheimer's disease patients and other patients, not to exceed one
1388 hundred fifty (150) beds. From and after July 1, 1999, there
1389 shall be no prohibition or restrictions on participation in the
1390 Medicaid program (Section 43-13-101 et seq.) for the beds in the
1391 nursing facilities that were authorized under this paragraph (b).

1392 (c) The department may issue a certificate of need for
1393 the addition to or expansion of any skilled nursing facility that
1394 is part of an existing continuing care retirement community
1395 located in Madison County, provided that the recipient of the
1396 certificate of need agrees in writing that the skilled nursing
1397 facility will not at any time participate in the Medicaid program
1398 (Section 43-13-101 et seq.) or admit or keep any patients in the
1399 skilled nursing facility who are participating in the Medicaid
1400 program. This written agreement by the recipient of the
1401 certificate of need shall be fully binding on any subsequent owner
1402 of the skilled nursing facility, if the ownership of the facility
1403 is transferred at any time after the issuance of the certificate
1404 of need. Agreement that the skilled nursing facility will not
1405 participate in the Medicaid program shall be a condition of the
1406 issuance of a certificate of need to any person under this
1407 paragraph (c), and if such skilled nursing facility at any time
1408 after the issuance of the certificate of need, regardless of the
1409 ownership of the facility, participates in the Medicaid program or
1410 admits or keeps any patients in the facility who are participating
1411 in the Medicaid program, the State Department of Health shall
1412 revoke the certificate of need, if it is still outstanding, and
1413 shall deny or revoke the license of the skilled nursing facility,
1414 at the time that the department determines, after a hearing
1415 complying with due process, that the facility has failed to comply
1416 with any of the conditions upon which the certificate of need was
1417 issued, as provided in this paragraph and in the written agreement
1418 by the recipient of the certificate of need. The total number of
1419 beds that may be authorized under the authority of this paragraph
1420 (c) shall not exceed sixty (60) beds.
1421 (d) The State Department of Health may issue a
1422 certificate of need to any hospital located in DeSoto County for
1423 the new construction of a skilled nursing facility, not to exceed
1424 one hundred twenty (120) beds, in DeSoto County. From and after

1425 July 1, 1999, there shall be no prohibition or restrictions on
1426 participation in the Medicaid program (Section 43-13-101 et seq.)
1427 for the beds in the nursing facility that were authorized under
1428 this paragraph (d).
1429 (e) The State Department of Health may issue a
1430 certificate of need for the construction of a nursing facility or
1431 the conversion of beds to nursing facility beds at a personal care
1432 facility for the elderly in Lowndes County that is owned and
1433 operated by a Mississippi nonprofit corporation, not to exceed
1434 sixty (60) beds. From and after July 1, 1999, there shall be no
1435 prohibition or restrictions on participation in the Medicaid
1436 program (Section 43-13-101 et seq.) for the beds in the nursing
1437 facility that were authorized under this paragraph (e).
1438 (f) The State Department of Health may issue a
1439 certificate of need for conversion of a county hospital facility
1440 in Itawamba County to a nursing facility, not to exceed sixty (60)
1441 beds, including any necessary construction, renovation or
1442 expansion. From and after July 1, 1999, there shall be no
1443 prohibition or restrictions on participation in the Medicaid
1444 program (Section 43-13-101 et seq.) for the beds in the nursing
1445 facility that were authorized under this paragraph (f).
1446 (g) The State Department of Health may issue a
1447 certificate of need for the construction or expansion of nursing
1448 facility beds or the conversion of other beds to nursing facility
1449 beds in either Hinds, Madison or Rankin County, not to exceed
1450 sixty (60) beds. From and after July 1, 1999, there shall be no
1451 prohibition or restrictions on participation in the Medicaid
1452 program (Section 43-13-101 et seq.) for the beds in the nursing
1453 facility that were authorized under this paragraph (g).
1454 (h) The State Department of Health may issue a
1455 certificate of need for the construction or expansion of nursing
1456 facility beds or the conversion of other beds to nursing facility
1457 beds in either Hancock, Harrison or Jackson County, not to exceed

1458 sixty (60) beds. From and after July 1, 1999, there shall be no
1459 prohibition or restrictions on participation in the Medicaid
1460 program (Section 43-13-101 et seq.) for the beds in the facility
1461 that were authorized under this paragraph (h).

1462 (i) The department may issue a certificate of need for
1463 the new construction of a skilled nursing facility in Leake
1464 County, provided that the recipient of the certificate of need
1465 agrees in writing that the skilled nursing facility will not at
1466 any time participate in the Medicaid program (Section 43-13-101 et
1467 seq.) or admit or keep any patients in the skilled nursing
1468 facility who are participating in the Medicaid program. This
1469 written agreement by the recipient of the certificate of need
1470 shall be fully binding on any subsequent owner of the skilled
1471 nursing facility, if the ownership of the facility is transferred
1472 at any time after the issuance of the certificate of need.
1473 Agreement that the skilled nursing facility will not participate
1474 in the Medicaid program shall be a condition of the issuance of a
1475 certificate of need to any person under this paragraph (i), and if
1476 such skilled nursing facility at any time after the issuance of
1477 the certificate of need, regardless of the ownership of the
1478 facility, participates in the Medicaid program or admits or keeps
1479 any patients in the facility who are participating in the Medicaid
1480 program, the State Department of Health shall revoke the
1481 certificate of need, if it is still outstanding, and shall deny or
1482 revoke the license of the skilled nursing facility, at the time
1483 that the department determines, after a hearing complying with due
1484 process, that the facility has failed to comply with any of the
1485 conditions upon which the certificate of need was issued, as
1486 provided in this paragraph and in the written agreement by the
1487 recipient of the certificate of need. The provision of Section
1488 43-7-193(1) regarding substantial compliance of the projection of
1489 need as reported in the current State Health Plan is waived for
1490 the purposes of this paragraph. The total number of nursing

1491 facility beds that may be authorized by any certificate of need
1492 issued under this paragraph (i) shall not exceed sixty (60) beds.
1493 If the skilled nursing facility authorized by the certificate of
1494 need issued under this paragraph is not constructed and fully
1495 operational within eighteen (18) months after July 1, 1994, the
1496 State Department of Health, after a hearing complying with due
1497 process, shall revoke the certificate of need, if it is still
1498 outstanding, and shall not issue a license for the skilled nursing
1499 facility at any time after the expiration of the eighteen-month
1500 period.
1501 (j) The department may issue certificates of need to
1502 allow any existing freestanding long-term care facility in
1503 Tishomingo County and Hancock County that on July 1, 1995, is
1504 licensed with fewer than sixty (60) beds. For the purposes of
1505 this paragraph (j), the provision of Section 41-7-193(1) requiring
1506 substantial compliance with the projection of need as reported in
1507 the current State Health Plan is waived. From and after July 1,
1508 1999, there shall be no prohibition or restrictions on
1509 participation in the Medicaid program (Section 43-13-101 et seq.)
1510 for the beds in the long-term care facilities that were authorized
1511 under this paragraph (j).
1512 (k) The department may issue a certificate of need for
1513 the construction of a nursing facility at a continuing care
1514 retirement community in Lowndes County. The total number of beds
1515 that may be authorized under the authority of this paragraph (k)
1516 shall not exceed sixty (60) beds. From and after July 1, 2001,
1517 the prohibition on the facility participating in the Medicaid
1518 program (Section 43-13-101 et seq.) that was a condition of
1519 issuance of the certificate of need under this paragraph (k) shall
1520 be revised as follows: The nursing facility may participate in
1521 the Medicaid program from and after July 1, 2001, if the owner of
1522 the facility on July 1, 2001, agrees in writing that no more than
1523 thirty (30) of the beds at the facility will be certified for

1524 participation in the Medicaid program, and that no claim will be
1525 submitted for Medicaid reimbursement for more than thirty (30)
1526 patients in the facility in any month or for any patient in the
1527 facility who is in a bed that is not Medicaid-certified. This
1528 written agreement by the owner of the facility shall be a
1529 condition of licensure of the facility, and the agreement shall be
1530 fully binding on any subsequent owner of the facility if the
1531 ownership of the facility is transferred at any time after July 1,
1532 2001. After this written agreement is executed, the Division of
1533 Medicaid and the State Department of Health shall not certify more
1534 than thirty (30) of the beds in the facility for participation in
1535 the Medicaid program. If the facility violates the terms of the
1536 written agreement by admitting or keeping in the facility on a
1537 regular or continuing basis more than thirty (30) patients who are
1538 participating in the Medicaid program, the State Department of
1539 Health shall revoke the license of the facility, at the time that
1540 the department determines, after a hearing complying with due
1541 process, that the facility has violated the written agreement.
1542 (l) Provided that funds are specifically appropriated
1543 therefor by the Legislature, the department may issue a
1544 certificate of need to a rehabilitation hospital in Hinds County
1545 for the construction of a sixty-bed long-term care nursing
1546 facility dedicated to the care and treatment of persons with
1547 severe disabilities including persons with spinal cord and
1548 closed-head injuries and ventilator-dependent patients. The
1549 provision of Section 41-7-193(1) regarding substantial compliance
1550 with projection of need as reported in the current State Health
1551 Plan is hereby waived for the purpose of this paragraph.
1552 (m) The State Department of Health may issue a
1553 certificate of need to a county-owned hospital in the Second
1554 Judicial District of Panola County for the conversion of not more
1555 than seventy-two (72) hospital beds to nursing facility beds,
1556 provided that the recipient of the certificate of need agrees in

1557 writing that none of the beds at the nursing facility will be
1558 certified for participation in the Medicaid program (Section
1559 43-13-101 et seq.), and that no claim will be submitted for
1560 Medicaid reimbursement in the nursing facility in any day or for
1561 any patient in the nursing facility. This written agreement by
1562 the recipient of the certificate of need shall be a condition of
1563 the issuance of the certificate of need under this paragraph, and
1564 the agreement shall be fully binding on any subsequent owner of
1565 the nursing facility if the ownership of the nursing facility is
1566 transferred at any time after the issuance of the certificate of
1567 need. After this written agreement is executed, the Division of
1568 Medicaid and the State Department of Health shall not certify any
1569 of the beds in the nursing facility for participation in the
1570 Medicaid program. If the nursing facility violates the terms of
1571 the written agreement by admitting or keeping in the nursing
1572 facility on a regular or continuing basis any patients who are
1573 participating in the Medicaid program, the State Department of
1574 Health shall revoke the license of the nursing facility, at the
1575 time that the department determines, after a hearing complying
1576 with due process, that the nursing facility has violated the
1577 condition upon which the certificate of need was issued, as
1578 provided in this paragraph and in the written agreement. If the
1579 certificate of need authorized under this paragraph is not issued
1580 within twelve (12) months after July 1, 2001, the department shall
1581 deny the application for the certificate of need and shall not
1582 issue the certificate of need at any time after the twelve-month
1583 period, unless the issuance is contested. If the certificate of
1584 need is issued and substantial construction of the nursing
1585 facility beds has not commenced within eighteen (18) months after
1586 July 1, 2001, the State Department of Health, after a hearing
1587 complying with due process, shall revoke the certificate of need
1588 if it is still outstanding, and the department shall not issue a
1589 license for the nursing facility at any time after the

1590 eighteen-month period. Provided, however, that if the issuance of
1591 the certificate of need is contested, the department shall require
1592 substantial construction of the nursing facility beds within six
1593 (6) months after final adjudication on the issuance of the
1594 certificate of need.

1595 (n) The department may issue a certificate of need for
1596 the new construction, addition or conversion of skilled nursing
1597 facility beds in Madison County, provided that the recipient of
1598 the certificate of need agrees in writing that the skilled nursing
1599 facility will not at any time participate in the Medicaid program
1600 (Section 43-13-101 et seq.) or admit or keep any patients in the
1601 skilled nursing facility who are participating in the Medicaid
1602 program. This written agreement by the recipient of the
1603 certificate of need shall be fully binding on any subsequent owner
1604 of the skilled nursing facility, if the ownership of the facility
1605 is transferred at any time after the issuance of the certificate
1606 of need. Agreement that the skilled nursing facility will not
1607 participate in the Medicaid program shall be a condition of the
1608 issuance of a certificate of need to any person under this
1609 paragraph (n), and if such skilled nursing facility at any time
1610 after the issuance of the certificate of need, regardless of the
1611 ownership of the facility, participates in the Medicaid program or
1612 admits or keeps any patients in the facility who are participating
1613 in the Medicaid program, the State Department of Health shall
1614 revoke the certificate of need, if it is still outstanding, and
1615 shall deny or revoke the license of the skilled nursing facility,
1616 at the time that the department determines, after a hearing
1617 complying with due process, that the facility has failed to comply
1618 with any of the conditions upon which the certificate of need was
1619 issued, as provided in this paragraph and in the written agreement
1620 by the recipient of the certificate of need. The total number of
1621 nursing facility beds that may be authorized by any certificate of
1622 need issued under this paragraph (n) shall not exceed sixty (60)

1623 beds. If the certificate of need authorized under this paragraph
1624 is not issued within twelve (12) months after July 1, 1998, the
1625 department shall deny the application for the certificate of need
1626 and shall not issue the certificate of need at any time after the
1627 twelve-month period, unless the issuance is contested. If the
1628 certificate of need is issued and substantial construction of the
1629 nursing facility beds has not commenced within eighteen (18)
1630 months after the effective date of July 1, 1998, the State
1631 Department of Health, after a hearing complying with due process,
1632 shall revoke the certificate of need if it is still outstanding,
1633 and the department shall not issue a license for the nursing
1634 facility at any time after the eighteen-month period. Provided,
1635 however, that if the issuance of the certificate of need is
1636 contested, the department shall require substantial construction
1637 of the nursing facility beds within six (6) months after final
1638 adjudication on the issuance of the certificate of need.
1639 (o) The department may issue a certificate of need for
1640 the new construction, addition or conversion of skilled nursing
1641 facility beds in Leake County, provided that the recipient of the
1642 certificate of need agrees in writing that the skilled nursing
1643 facility will not at any time participate in the Medicaid program
1644 (Section 43-13-101 et seq.) or admit or keep any patients in the
1645 skilled nursing facility who are participating in the Medicaid
1646 program. This written agreement by the recipient of the
1647 certificate of need shall be fully binding on any subsequent owner
1648 of the skilled nursing facility, if the ownership of the facility
1649 is transferred at any time after the issuance of the certificate
1650 of need. Agreement that the skilled nursing facility will not
1651 participate in the Medicaid program shall be a condition of the
1652 issuance of a certificate of need to any person under this
1653 paragraph (o), and if such skilled nursing facility at any time
1654 after the issuance of the certificate of need, regardless of the
1655 ownership of the facility, participates in the Medicaid program or

1656 admits or keeps any patients in the facility who are participating
1657 in the Medicaid program, the State Department of Health shall
1658 revoke the certificate of need, if it is still outstanding, and
1659 shall deny or revoke the license of the skilled nursing facility,
1660 at the time that the department determines, after a hearing
1661 complying with due process, that the facility has failed to comply
1662 with any of the conditions upon which the certificate of need was
1663 issued, as provided in this paragraph and in the written agreement
1664 by the recipient of the certificate of need. The total number of
1665 nursing facility beds that may be authorized by any certificate of
1666 need issued under this paragraph (o) shall not exceed sixty (60)
1667 beds. If the certificate of need authorized under this paragraph
1668 is not issued within twelve (12) months after July 1, 2001, the
1669 department shall deny the application for the certificate of need
1670 and shall not issue the certificate of need at any time after the
1671 twelve-month period, unless the issuance is contested. If the
1672 certificate of need is issued and substantial construction of the
1673 nursing facility beds has not commenced within eighteen (18)
1674 months after the effective date of July 1, 2001, the State
1675 Department of Health, after a hearing complying with due process,
1676 shall revoke the certificate of need if it is still outstanding,
1677 and the department shall not issue a license for the nursing
1678 facility at any time after the eighteen-month period. Provided,
1679 however, that if the issuance of the certificate of need is
1680 contested, the department shall require substantial construction
1681 of the nursing facility beds within six (6) months after final
1682 adjudication on the issuance of the certificate of need.
1683 (p) The department may issue a certificate of need for
1684 the construction of a municipally-owned nursing facility within
1685 the Town of Belmont in Tishomingo County, not to exceed sixty (60)
1686 beds, provided that the recipient of the certificate of need
1687 agrees in writing that the skilled nursing facility will not at
1688 any time participate in the Medicaid program (Section 43-13-101 et

1689 seq.) or admit or keep any patients in the skilled nursing
1690 facility who are participating in the Medicaid program. This
1691 written agreement by the recipient of the certificate of need
1692 shall be fully binding on any subsequent owner of the skilled
1693 nursing facility, if the ownership of the facility is transferred
1694 at any time after the issuance of the certificate of need.
1695 Agreement that the skilled nursing facility will not participate
1696 in the Medicaid program shall be a condition of the issuance of a
1697 certificate of need to any person under this paragraph (p), and if
1698 such skilled nursing facility at any time after the issuance of
1699 the certificate of need, regardless of the ownership of the
1700 facility, participates in the Medicaid program or admits or keeps
1701 any patients in the facility who are participating in the Medicaid
1702 program, the State Department of Health shall revoke the
1703 certificate of need, if it is still outstanding, and shall deny or
1704 revoke the license of the skilled nursing facility, at the time
1705 that the department determines, after a hearing complying with due
1706 process, that the facility has failed to comply with any of the
1707 conditions upon which the certificate of need was issued, as
1708 provided in this paragraph and in the written agreement by the
1709 recipient of the certificate of need. The provision of Section
1710 43-7-193(1) regarding substantial compliance of the projection of
1711 need as reported in the current State Health Plan is waived for
1712 the purposes of this paragraph. If the certificate of need
1713 authorized under this paragraph is not issued within twelve (12)
1714 months after July 1, 1998, the department shall deny the
1715 application for the certificate of need and shall not issue the
1716 certificate of need at any time after the twelve-month period,
1717 unless the issuance is contested. If the certificate of need is
1718 issued and substantial construction of the nursing facility beds
1719 has not commenced within eighteen (18) months after July 1, 1998,
1720 the State Department of Health, after a hearing complying with due
1721 process, shall revoke the certificate of need if it is still

1722 outstanding, and the department shall not issue a license for the
1723 nursing facility at any time after the eighteen-month period.
1724 Provided, however, that if the issuance of the certificate of need
1725 is contested, the department shall require substantial
1726 construction of the nursing facility beds within six (6) months
1727 after final adjudication on the issuance of the certificate of
1728 need.

1729 (q) (i) Beginning on July 1, 1999, the State
1730 Department of Health shall issue certificates of need during each
1731 of the next four (4) fiscal years for the construction or
1732 expansion of nursing facility beds or the conversion of other beds
1733 to nursing facility beds in each county in the state having a need
1734 for fifty (50) or more additional nursing facility beds, as shown
1735 in the fiscal year 1999 State Health Plan, in the manner provided
1736 in this paragraph (q). The total number of nursing facility beds
1737 that may be authorized by any certificate of need authorized under
1738 this paragraph (q) shall not exceed sixty (60) beds.

1739 (ii) Subject to the provisions of subparagraph
1740 (v), during each of the next four (4) fiscal years, the department
1741 shall issue six (6) certificates of need for new nursing facility
1742 beds, as follows: During fiscal years 2000, 2001 and 2002, one
1743 (1) certificate of need shall be issued for new nursing facility
1744 beds in the county in each of the four (4) Long-Term Care Planning
1745 Districts designated in the fiscal year 1999 State Health Plan
1746 that has the highest need in the district for those beds; and two
1747 (2) certificates of need shall be issued for new nursing facility
1748 beds in the two (2) counties from the state at large that have the
1749 highest need in the state for those beds, when considering the
1750 need on a statewide basis and without regard to the Long-Term Care
1751 Planning Districts in which the counties are located. During
1752 fiscal year 2003, one (1) certificate of need shall be issued for
1753 new nursing facility beds in any county having a need for fifty
1754 (50) or more additional nursing facility beds, as shown in the

1755 fiscal year 1999 State Health Plan, that has not received a
1756 certificate of need under this paragraph (q) during the three (3)
1757 previous fiscal years. During fiscal year 2000, in addition to
1758 the six (6) certificates of need authorized in this subparagraph,
1759 the department also shall issue a certificate of need for new
1760 nursing facility beds in Amite County and a certificate of need
1761 for new nursing facility beds in Carroll County.

1762 (iii) Subject to the provisions of subparagraph
1763 (v), the certificate of need issued under subparagraph (ii) for
1764 nursing facility beds in each Long-Term Care Planning District
1765 during each fiscal year shall first be available for nursing
1766 facility beds in the county in the district having the highest
1767 need for those beds, as shown in the fiscal year 1999 State Health
1768 Plan. If there are no applications for a certificate of need for
1769 nursing facility beds in the county having the highest need for
1770 those beds by the date specified by the department, then the
1771 certificate of need shall be available for nursing facility beds
1772 in other counties in the district in descending order of the need
1773 for those beds, from the county with the second highest need to
1774 the county with the lowest need, until an application is received
1775 for nursing facility beds in an eligible county in the district.

1776 (iv) Subject to the provisions of subparagraph
1777 (v), the certificate of need issued under subparagraph (ii) for
1778 nursing facility beds in the two (2) counties from the state at
1779 large during each fiscal year shall first be available for nursing
1780 facility beds in the two (2) counties that have the highest need
1781 in the state for those beds, as shown in the fiscal year 1999
1782 State Health Plan, when considering the need on a statewide basis
1783 and without regard to the Long-Term Care Planning Districts in
1784 which the counties are located. If there are no applications for
1785 a certificate of need for nursing facility beds in either of the
1786 two (2) counties having the highest need for those beds on a
1787 statewide basis by the date specified by the department, then the

1788 certificate of need shall be available for nursing facility beds
1789 in other counties from the state at large in descending order of
1790 the need for those beds on a statewide basis, from the county with
1791 the second highest need to the county with the lowest need, until
1792 an application is received for nursing facility beds in an
1793 eligible county from the state at large.

1794 (v) If a certificate of need is authorized to be
1795 issued under this paragraph (q) for nursing facility beds in a
1796 county on the basis of the need in the Long-Term Care Planning
1797 District during any fiscal year of the four-year period, a
1798 certificate of need shall not also be available under this
1799 paragraph (q) for additional nursing facility beds in that county
1800 on the basis of the need in the state at large, and that county
1801 shall be excluded in determining which counties have the highest
1802 need for nursing facility beds in the state at large for that
1803 fiscal year. After a certificate of need has been issued under
1804 this paragraph (q) for nursing facility beds in a county during
1805 any fiscal year of the four-year period, a certificate of need
1806 shall not be available again under this paragraph (q) for
1807 additional nursing facility beds in that county during the
1808 four-year period, and that county shall be excluded in determining
1809 which counties have the highest need for nursing facility beds in
1810 succeeding fiscal years.

1811 (vi) If more than one (1) application is made for
1812 a certificate of need for nursing home facility beds available
1813 under this paragraph (q), in Yalobusha, Newton or Tallahatchie
1814 County, and one (1) of the applicants is a county-owned hospital
1815 located in the county where the nursing facility beds are
1816 available, the department shall give priority to the county-owned
1817 hospital in granting the certificate of need if the following
1818 conditions are met:

1819 1. The county-owned hospital fully meets all
1820 applicable criteria and standards required to obtain a certificate
1821 of need for the nursing facility beds; and
1822 2. The county-owned hospital's qualifications
1823 for the certificate of need, as shown in its application and as
1824 determined by the department, are at least equal to the
1825 qualifications of the other applicants for the certificate of
1826 need.
1827 (r) (i) Beginning on July 1, 1999, the State
1828 Department of Health shall issue certificates of need during each
1829 of the next two (2) fiscal years for the construction or expansion
1830 of nursing facility beds or the conversion of other beds to
1831 nursing facility beds in each of the four (4) Long-Term Care
1832 Planning Districts designated in the fiscal year 1999 State Health
1833 Plan, to provide care exclusively to patients with Alzheimer's
1834 disease.
1835 (ii) Not more than twenty (20) beds may be
1836 authorized by any certificate of need issued under this paragraph
1837 (r), and not more than a total of sixty (60) beds may be
1838 authorized in any Long-Term Care Planning District by all
1839 certificates of need issued under this paragraph (r). However,
1840 the total number of beds that may be authorized by all
1841 certificates of need issued under this paragraph (r) during any
1842 fiscal year shall not exceed one hundred twenty (120) beds, and
1843 the total number of beds that may be authorized in any Long-Term
1844 Care Planning District during any fiscal year shall not exceed
1845 forty (40) beds. Of the certificates of need that are issued for
1846 each Long-Term Care Planning District during the next two (2)
1847 fiscal years, at least one (1) shall be issued for beds in the
1848 northern part of the district, at least one (1) shall be issued
1849 for beds in the central part of the district, and at least one (1)
1850 shall be issued for beds in the southern part of the district.

1851 (iii) The State Department of Health, in
1852 consultation with the Department of Mental Health and the Division
1853 of Medicaid, shall develop and prescribe the staffing levels,
1854 space requirements and other standards and requirements that must
1855 be met with regard to the nursing facility beds authorized under
1856 this paragraph (r) to provide care exclusively to patients with
1857 Alzheimer's disease.
1858 (3) The State Department of Health may grant approval for
1859 and issue certificates of need to any person proposing the new
1860 construction of, addition to, conversion of beds of or expansion
1861 of any health care facility defined in subparagraph (x)
1862 (psychiatric residential treatment facility) of Section
1863 41-7-173(h). The total number of beds which may be authorized by
1864 such certificates of need shall not exceed three hundred
1865 thirty-four (334) beds for the entire state.
1866 (a) Of the total number of beds authorized under this
1867 subsection, the department shall issue a certificate of need to a
1868 privately-owned psychiatric residential treatment facility in
1869 Simpson County for the conversion of sixteen (16) intermediate
1870 care facility for the mentally retarded (ICF-MR) beds to
1871 psychiatric residential treatment facility beds, provided that
1872 facility agrees in writing that the facility shall give priority
1873 for the use of those sixteen (16) beds to Mississippi residents
1874 who are presently being treated in out-of-state facilities.
1875 (b) Of the total number of beds authorized under this
1876 subsection, the department may issue a certificate or certificates
1877 of need for the construction or expansion of psychiatric
1878 residential treatment facility beds or the conversion of other
1879 beds to psychiatric residential treatment facility beds in Warren
1880 County, not to exceed sixty (60) psychiatric residential treatment
1881 facility beds, provided that the facility agrees in writing that
1882 no more than thirty (30) of the beds at the psychiatric
1883 residential treatment facility will be certified for participation

1884 in the Medicaid program (Section 43-13-101 et seq.) for the use of
1885 any patients other than those who are participating only in the
1886 Medicaid program of another state, and that no claim will be
1887 submitted to the Division of Medicaid for Medicaid reimbursement
1888 for more than thirty (30) patients in the psychiatric residential
1889 treatment facility in any day or for any patient in the
1890 psychiatric residential treatment facility who is in a bed that is
1891 not Medicaid-certified. This written agreement by the recipient
1892 of the certificate of need shall be a condition of the issuance of
1893 the certificate of need under this paragraph, and the agreement
1894 shall be fully binding on any subsequent owner of the psychiatric
1895 residential treatment facility if the ownership of the facility is
1896 transferred at any time after the issuance of the certificate of
1897 need. After this written agreement is executed, the Division of
1898 Medicaid and the State Department of Health shall not certify more
1899 than thirty (30) of the beds in the psychiatric residential
1900 treatment facility for participation in the Medicaid program for
1901 the use of any patients other than those who are participating
1902 only in the Medicaid program of another state. If the psychiatric
1903 residential treatment facility violates the terms of the written
1904 agreement by admitting or keeping in the facility on a regular or
1905 continuing basis more than thirty (30) patients who are
1906 participating in the Mississippi Medicaid program, the State
1907 Department of Health shall revoke the license of the facility, at
1908 the time that the department determines, after a hearing complying
1909 with due process, that the facility has violated the condition
1910 upon which the certificate of need was issued, as provided in this
1911 paragraph and in the written agreement.
1912 The State Department of Health, on or before July 1, 2002,
1913 shall transfer the certificate of need authorized under the
1914 authority of this paragraph (b), or reissue the certificate of
1915 need if it has expired, to River Region Health System.

1916 (c) Of the total number of beds authorized under this
1917 subsection, the department shall issue a certificate of need to a
1918 hospital currently operating Medicaid-certified acute psychiatric
1919 beds for adolescents in DeSoto County, for the establishment of a
1920 forty-bed psychiatric residential treatment facility in DeSoto
1921 County, provided that the hospital agrees in writing (i) that the
1922 hospital shall give priority for the use of those forty (40) beds
1923 to Mississippi residents who are presently being treated in
1924 out-of-state facilities, and (ii) that no more than fifteen (15)
1925 of the beds at the psychiatric residential treatment facility will
1926 be certified for participation in the Medicaid program (Section
1927 43-13-101 et seq.), and that no claim will be submitted for
1928 Medicaid reimbursement for more than fifteen (15) patients in the
1929 psychiatric residential treatment facility in any day or for any
1930 patient in the psychiatric residential treatment facility who is
1931 in a bed that is not Medicaid-certified. This written agreement
1932 by the recipient of the certificate of need shall be a condition
1933 of the issuance of the certificate of need under this paragraph,
1934 and the agreement shall be fully binding on any subsequent owner
1935 of the psychiatric residential treatment facility if the ownership
1936 of the facility is transferred at any time after the issuance of
1937 the certificate of need. After this written agreement is
1938 executed, the Division of Medicaid and the State Department of
1939 Health shall not certify more than fifteen (15) of the beds in the
1940 psychiatric residential treatment facility for participation in
1941 the Medicaid program. If the psychiatric residential treatment
1942 facility violates the terms of the written agreement by admitting
1943 or keeping in the facility on a regular or continuing basis more
1944 than fifteen (15) patients who are participating in the Medicaid
1945 program, the State Department of Health shall revoke the license
1946 of the facility, at the time that the department determines, after
1947 a hearing complying with due process, that the facility has
1948 violated the condition upon which the certificate of need was

1949 issued, as provided in this paragraph and in the written
1950 agreement.
1951 (d) Of the total number of beds authorized under this
1952 subsection, the department may issue a certificate or certificates
1953 of need for the construction or expansion of psychiatric
1954 residential treatment facility beds or the conversion of other
1955 beds to psychiatric treatment facility beds, not to exceed thirty
1956 (30) psychiatric residential treatment facility beds, in either
1957 Alcorn, Tishomingo, Prentiss, Lee, Itawamba, Monroe, Chickasaw,
1958 Pontotoc, Calhoun, Lafayette, Union, Benton or Tippah County.
1959 (e) Of the total number of beds authorized under this
1960 subsection (3) the department shall issue a certificate of need to
1961 a privately-owned, nonprofit psychiatric residential treatment
1962 facility in Hinds County for an eight-bed expansion of the
1963 facility, provided that the facility agrees in writing that the
1964 facility shall give priority for the use of those eight (8) beds
1965 to Mississippi residents who are presently being treated in
1966 out-of-state facilities.
1967 (f) The department shall issue a certificate of need to
1968 a one-hundred-thirty-four-bed specialty hospital located on
1969 twenty-nine and forty-four one-hundredths (29.44) commercial acres
1970 at 5900 Highway 39 North in Meridian (Lauderdale County),
1971 Mississippi, for the addition, construction or expansion of
1972 child/adolescent psychiatric residential treatment facility beds
1973 in Lauderdale County. As a condition of issuance of the
1974 certificate of need under this paragraph, the facility shall give
1975 priority in admissions to the child/adolescent psychiatric
1976 residential treatment facility beds authorized under this
1977 paragraph to patients who otherwise would require out-of-state
1978 placement. The Division of Medicaid, in conjunction with the
1979 Department of Human Services, shall furnish the facility a list of
1980 all out-of-state patients on a quarterly basis. Furthermore,
1981 notice shall also be provided to the parent, custodial parent or

1982 guardian of each out-of-state patient notifying them of the
1983 priority status granted by this paragraph. For purposes of this
1984 paragraph, the provisions of Section 41-7-193(1) requiring
1985 substantial compliance with the projection of need as reported in
1986 the current State Health Plan are waived. The total number of
1987 child/adolescent psychiatric residential treatment facility beds
1988 that may be authorized under the authority of this paragraph shall
1989 be sixty (60) beds. There shall be no prohibition or restrictions
1990 on participation in the Medicaid program (Section 43-13-101 et
1991 seq.) for the person receiving the certificate of need authorized
1992 under this paragraph or for the beds converted pursuant to the
1993 authority of that certificate of need.

1994 (4) (a) From and after July 1, 1993, the department shall
1995 not issue a certificate of need to any person for the new
1996 construction of any hospital, psychiatric hospital or chemical
1997 dependency hospital that will contain any child/adolescent
1998 psychiatric or child/adolescent chemical dependency beds, or for
1999 the conversion of any other health care facility to a hospital,
2000 psychiatric hospital or chemical dependency hospital that will
2001 contain any child/adolescent psychiatric or child/adolescent
2002 chemical dependency beds, or for the addition of any
2003 child/adolescent psychiatric or child/adolescent chemical
2004 dependency beds in any hospital, psychiatric hospital or chemical
2005 dependency hospital, or for the conversion of any beds of another
2006 category in any hospital, psychiatric hospital or chemical
2007 dependency hospital to child/adolescent psychiatric or
2008 child/adolescent chemical dependency beds, except as hereinafter
2009 authorized:

2010 (i) The department may issue certificates of need
2011 to any person for any purpose described in this subsection,
2012 provided that the hospital, psychiatric hospital or chemical
2013 dependency hospital does not participate in the Medicaid program
2014 (Section 43-13-101 et seq.) at the time of the application for the

2015 certificate of need and the owner of the hospital, psychiatric
2016 hospital or chemical dependency hospital agrees in writing that
2017 the hospital, psychiatric hospital or chemical dependency hospital
2018 will not at any time participate in the Medicaid program or admit
2019 or keep any patients who are participating in the Medicaid program
2020 in the hospital, psychiatric hospital or chemical dependency
2021 hospital. This written agreement by the recipient of the
2022 certificate of need shall be fully binding on any subsequent owner
2023 of the hospital, psychiatric hospital or chemical dependency
2024 hospital, if the ownership of the facility is transferred at any
2025 time after the issuance of the certificate of need. Agreement
2026 that the hospital, psychiatric hospital or chemical dependency
2027 hospital will not participate in the Medicaid program shall be a
2028 condition of the issuance of a certificate of need to any person
2029 under this subparagraph (a)(i), and if such hospital, psychiatric
2030 hospital or chemical dependency hospital at any time after the
2031 issuance of the certificate of need, regardless of the ownership
2032 of the facility, participates in the Medicaid program or admits or
2033 keeps any patients in the hospital, psychiatric hospital or
2034 chemical dependency hospital who are participating in the Medicaid
2035 program, the State Department of Health shall revoke the
2036 certificate of need, if it is still outstanding, and shall deny or
2037 revoke the license of the hospital, psychiatric hospital or
2038 chemical dependency hospital, at the time that the department
2039 determines, after a hearing complying with due process, that the
2040 hospital, psychiatric hospital or chemical dependency hospital has
2041 failed to comply with any of the conditions upon which the
2042 certificate of need was issued, as provided in this subparagraph
2043 and in the written agreement by the recipient of the certificate
2044 of need.

2045 (ii) The department may issue a certificate of
2046 need for the conversion of existing beds in a county hospital in
2047 Choctaw County from acute care beds to child/adolescent chemical

2048 dependency beds. For purposes of this subparagraph, the
2049 provisions of Section 41-7-193(1) requiring substantial compliance
2050 with the projection of need as reported in the current State
2051 Health Plan is waived. The total number of beds that may be
2052 authorized under authority of this subparagraph shall not exceed
2053 twenty (20) beds. There shall be no prohibition or restrictions
2054 on participation in the Medicaid program (Section 43-13-101 et
2055 seq.) for the hospital receiving the certificate of need
2056 authorized under this subparagraph (a)(ii) or for the beds
2057 converted pursuant to the authority of that certificate of need.
2058 (iii) The department may issue a certificate or
2059 certificates of need for the construction or expansion of
2060 child/adolescent psychiatric beds or the conversion of other beds
2061 to child/adolescent psychiatric beds in Warren County. For
2062 purposes of this subparagraph, the provisions of Section
2063 41-7-193(1) requiring substantial compliance with the projection
2064 of need as reported in the current State Health Plan are waived.
2065 The total number of beds that may be authorized under the
2066 authority of this subparagraph shall not exceed twenty (20) beds.
2067 There shall be no prohibition or restrictions on participation in
2068 the Medicaid program (Section 43-13-101 et seq.) for the person
2069 receiving the certificate of need authorized under this
2070 subparagraph (a)(iii) or for the beds converted pursuant to the
2071 authority of that certificate of need.
2072 If by January 1, 2002, there has been no significant
2073 commencement of construction of the beds authorized under this
2074 subparagraph (a)(iii), or no significant action taken to convert
2075 existing beds to the beds authorized under this subparagraph, then
2076 the certificate of need that was previously issued under this
2077 subparagraph shall expire. If the previously issued certificate
2078 of need expires, the department may accept applications for
2079 issuance of another certificate of need for the beds authorized
2080 under this subparagraph, and may issue a certificate of need to

2081 authorize the construction, expansion or conversion of the beds
2082 authorized under this subparagraph.
2083 (iv) The department shall issue a certificate of
2084 need to the Region 7 Mental Health/Retardation Commission for the
2085 construction or expansion of child/adolescent psychiatric beds or
2086 the conversion of other beds to child/adolescent psychiatric beds
2087 in any of the counties served by the commission. For purposes of
2088 this subparagraph, the provisions of Section 41-7-193(1) requiring
2089 substantial compliance with the projection of need as reported in
2090 the current State Health Plan is waived. The total number of beds
2091 that may be authorized under the authority of this subparagraph
2092 shall not exceed twenty (20) beds. There shall be no prohibition
2093 or restrictions on participation in the Medicaid program (Section
2094 43-13-101 et seq.) for the person receiving the certificate of
2095 need authorized under this subparagraph (a)(iv) or for the beds
2096 converted pursuant to the authority of that certificate of need.
2097 (v) The department may issue a certificate of need
2098 to any county hospital located in Leflore County for the
2099 construction or expansion of adult psychiatric beds or the
2100 conversion of other beds to adult psychiatric beds, not to exceed
2101 twenty (20) beds, provided that the recipient of the certificate
2102 of need agrees in writing that the adult psychiatric beds will not
2103 at any time be certified for participation in the Medicaid program
2104 and that the hospital will not admit or keep any patients who are
2105 participating in the Medicaid program in any of such adult
2106 psychiatric beds. This written agreement by the recipient of the
2107 certificate of need shall be fully binding on any subsequent owner
2108 of the hospital if the ownership of the hospital is transferred at
2109 any time after the issuance of the certificate of need. Agreement
2110 that the adult psychiatric beds will not be certified for
2111 participation in the Medicaid program shall be a condition of the
2112 issuance of a certificate of need to any person under this
2113 subparagraph (a)(v), and if such hospital at any time after the

2114 issuance of the certificate of need, regardless of the ownership
2115 of the hospital, has any of such adult psychiatric beds certified
2116 for participation in the Medicaid program or admits or keeps any
2117 Medicaid patients in such adult psychiatric beds, the State
2118 Department of Health shall revoke the certificate of need, if it
2119 is still outstanding, and shall deny or revoke the license of the
2120 hospital at the time that the department determines, after a
2121 hearing complying with due process, that the hospital has failed
2122 to comply with any of the conditions upon which the certificate of
2123 need was issued, as provided in this subparagraph and in the
2124 written agreement by the recipient of the certificate of need.
2125 (vi) The department may issue a certificate or
2126 certificates of need for the expansion of child psychiatric beds
2127 or the conversion of other beds to child psychiatric beds at the
2128 University of Mississippi Medical Center. For purposes of this
2129 subparagraph (a)(vi), the provision of Section 41-7-193(1)
2130 requiring substantial compliance with the projection of need as
2131 reported in the current State Health Plan is waived. The total
2132 number of beds that may be authorized under the authority of this
2133 subparagraph (a)(vi) shall not exceed fifteen (15) beds. There
2134 shall be no prohibition or restrictions on participation in the
2135 Medicaid program (Section 43-13-101 et seq.) for the hospital
2136 receiving the certificate of need authorized under this
2137 subparagraph (a)(vi) or for the beds converted pursuant to the
2138 authority of that certificate of need.
2139 (b) From and after July 1, 1990, no hospital,
2140 psychiatric hospital or chemical dependency hospital shall be
2141 authorized to add any child/adolescent psychiatric or
2142 child/adolescent chemical dependency beds or convert any beds of
2143 another category to child/adolescent psychiatric or
2144 child/adolescent chemical dependency beds without a certificate of
2145 need under the authority of subsection (1)(c) of this section.

2146 (5) The department may issue a certificate of need to a
2147 county hospital in Winston County for the conversion of fifteen
2148 (15) acute care beds to geriatric psychiatric care beds.
2149 (6) The State Department of Health shall issue a certificate
2150 of need to a Mississippi corporation qualified to manage a
2151 long-term care hospital as defined in Section 41-7-173(h)(xii) in
2152 Harrison County, not to exceed eighty (80) beds, including any
2153 necessary renovation or construction required for licensure and
2154 certification, provided that the recipient of the certificate of
2155 need agrees in writing that the long-term care hospital will not
2156 at any time participate in the Medicaid program (Section 43-13-101
2157 et seq.) or admit or keep any patients in the long-term care
2158 hospital who are participating in the Medicaid program. This
2159 written agreement by the recipient of the certificate of need
2160 shall be fully binding on any subsequent owner of the long-term
2161 care hospital, if the ownership of the facility is transferred at
2162 any time after the issuance of the certificate of need. Agreement
2163 that the long-term care hospital will not participate in the
2164 Medicaid program shall be a condition of the issuance of a
2165 certificate of need to any person under this subsection (6), and
2166 if such long-term care hospital at any time after the issuance of
2167 the certificate of need, regardless of the ownership of the
2168 facility, participates in the Medicaid program or admits or keeps
2169 any patients in the facility who are participating in the Medicaid
2170 program, the State Department of Health shall revoke the
2171 certificate of need, if it is still outstanding, and shall deny or
2172 revoke the license of the long-term care hospital, at the time
2173 that the department determines, after a hearing complying with due
2174 process, that the facility has failed to comply with any of the
2175 conditions upon which the certificate of need was issued, as
2176 provided in this subsection and in the written agreement by the
2177 recipient of the certificate of need. For purposes of this
2178 subsection, the provision of Section 41-7-193(1) requiring

2179 substantial compliance with the projection of need as reported in
2180 the current State Health Plan is hereby waived.
2181 (7) The State Department of Health may issue a certificate
2182 of need to any hospital in the state to utilize a portion of its
2183 beds for the "swing-bed" concept. Any such hospital must be in
2184 conformance with the federal regulations regarding such swing-bed
2185 concept at the time it submits its application for a certificate
2186 of need to the State Department of Health, except that such
2187 hospital may have more licensed beds or a higher average daily
2188 census (ADC) than the maximum number specified in federal
2189 regulations for participation in the swing-bed program. Any
2190 hospital meeting all federal requirements for participation in the
2191 swing-bed program which receives such certificate of need shall
2192 render services provided under the swing-bed concept to any
2193 patient eligible for Medicare (Title XVIII of the Social Security
2194 Act) who is certified by a physician to be in need of such
2195 services, and no such hospital shall permit any patient who is
2196 eligible for both Medicaid and Medicare or eligible only for
2197 Medicaid to stay in the swing beds of the hospital for more than
2198 thirty (30) days per admission unless the hospital receives prior
2199 approval for such patient from the Division of Medicaid, Office of
2200 the Governor. Any hospital having more licensed beds or a higher
2201 average daily census (ADC) than the maximum number specified in
2202 federal regulations for participation in the swing-bed program
2203 which receives such certificate of need shall develop a procedure
2204 to insure that before a patient is allowed to stay in the swing
2205 beds of the hospital, there are no vacant nursing home beds
2206 available for that patient located within a fifty-mile radius of
2207 the hospital. When any such hospital has a patient staying in the
2208 swing beds of the hospital and the hospital receives notice from a
2209 nursing home located within such radius that there is a vacant bed
2210 available for that patient, the hospital shall transfer the
2211 patient to the nursing home within a reasonable time after receipt

2212 of the notice. Any hospital which is subject to the requirements
2213 of the two (2) preceding sentences of this subsection may be
2214 suspended from participation in the swing-bed program for a
2215 reasonable period of time by the State Department of Health if the
2216 department, after a hearing complying with due process, determines
2217 that the hospital has failed to comply with any of those
2218 requirements.
2219 (8) The Department of Health shall not grant approval for or
2220 issue a certificate of need to any person proposing the new
2221 construction of, addition to or expansion of a health care
2222 facility as defined in subparagraph (viii) of Section 41-7-173(h).
2223 (9) The Department of Health shall not grant approval for or
2224 issue a certificate of need to any person proposing the
2225 establishment of, or expansion of the currently approved territory
2226 of, or the contracting to establish a home office, subunit or
2227 branch office within the space operated as a health care facility
2228 as defined in Section 41-7-173(h)(i) through (viii) by a health
2229 care facility as defined in subparagraph (ix) of Section
2230 41-7-173(h).
2231 (10) Health care facilities owned and/or operated by the
2232 state or its agencies are exempt from the restraints in this
2233 section against issuance of a certificate of need if such addition
2234 or expansion consists of repairing or renovation necessary to
2235 comply with the state licensure law. This exception shall not
2236 apply to the new construction of any building by such state
2237 facility. This exception shall not apply to any health care
2238 facilities owned and/or operated by counties, municipalities,
2239 districts, unincorporated areas, other defined persons, or any
2240 combination thereof.
2241 (11) The new construction, renovation or expansion of or
2242 addition to any health care facility defined in subparagraph (ii)
2243 (psychiatric hospital), subparagraph (iv) (skilled nursing
2244 facility), subparagraph (vi) (intermediate care facility),

2245 subparagraph (viii) (intermediate care facility for the mentally
2246 retarded) and subparagraph (x) (psychiatric residential treatment
2247 facility) of Section 41-7-173(h) which is owned by the State of
2248 Mississippi and under the direction and control of the State
2249 Department of Mental Health, and the addition of new beds or the
2250 conversion of beds from one category to another in any such
2251 defined health care facility which is owned by the State of
2252 Mississippi and under the direction and control of the State
2253 Department of Mental Health, shall not require the issuance of a
2254 certificate of need under Section 41-7-171 et seq.,
2255 notwithstanding any provision in Section 41-7-171 et seq. to the
2256 contrary.
2257 (12) The new construction, renovation or expansion of or
2258 addition to any veterans homes or domiciliaries for eligible
2259 veterans of the State of Mississippi as authorized under Section
2260 35-1-19 shall not require the issuance of a certificate of need,
2261 notwithstanding any provision in Section 41-7-171 et seq. to the
2262 contrary.
2263 (13) The new construction of a nursing facility or nursing
2264 facility beds or the conversion of other beds to nursing facility
2265 beds shall not require the issuance of a certificate of need,
2266 notwithstanding any provision in Section 41-7-171 et seq. to the
2267 contrary, if the conditions of this subsection are met.
2268 (a) Before any construction or conversion may be
2269 undertaken without a certificate of need, the owner of the nursing
2270 facility, in the case of an existing facility, or the applicant to
2271 construct a nursing facility, in the case of new construction,
2272 first must file a written notice of intent and sign a written
2273 agreement with the State Department of Health that the entire
2274 nursing facility will not at any time participate in or have any
2275 beds certified for participation in the Medicaid program (Section
2276 43-13-101 et seq.), will not admit or keep any patients in the
2277 nursing facility who are participating in the Medicaid program,

2278 and will not submit any claim for Medicaid reimbursement for any
2279 patient in the facility. This written agreement by the owner or
2280 applicant shall be a condition of exercising the authority under
2281 this subsection without a certificate of need, and the agreement
2282 shall be fully binding on any subsequent owner of the nursing
2283 facility if the ownership of the facility is transferred at any
2284 time after the agreement is signed. After the written agreement
2285 is signed, the Division of Medicaid and the State Department of
2286 Health shall not certify any beds in the nursing facility for
2287 participation in the Medicaid program. If the nursing facility
2288 violates the terms of the written agreement by participating in
2289 the Medicaid program, having any beds certified for participation
2290 in the Medicaid program, admitting or keeping any patient in the
2291 facility who is participating in the Medicaid program, or
2292 submitting any claim for Medicaid reimbursement for any patient in
2293 the facility, the State Department of Health shall revoke the
2294 license of the nursing facility at the time that the department
2295 determines, after a hearing complying with due process, that the
2296 facility has violated the terms of the written agreement.
2297 (b) For the purposes of this subsection, participation
2298 in the Medicaid program by a nursing facility includes Medicaid
2299 reimbursement of coinsurance and deductibles for recipients who
2300 are qualified Medicare beneficiaries and/or those who are dually
2301 eligible. Any nursing facility exercising the authority under
2302 this subsection may not bill or submit a claim to the Division of
2303 Medicaid for services to qualified Medicare beneficiaries and/or
2304 those who are dually eligible.
2305 (c) The new construction of a nursing facility or
2306 nursing facility beds or the conversion of other beds to nursing
2307 facility beds described in this section must be either a part of a
2308 completely new continuing care retirement community, as described
2309 in the latest edition of the Mississippi State Health Plan, or an
2310 addition to existing personal care and independent living

2311 components, and so that the completed project will be a continuing
2312 care retirement community, containing (i) independent living
2313 accommodations, (ii) personal care beds, and (iii) the nursing
2314 home facility beds. The three (3) components must be located on a
2315 single site and be operated as one (1) inseparable facility. The
2316 nursing facility component must contain a minimum of thirty (30)
2317 beds. Any nursing facility beds authorized by this section will
2318 not be counted against the bed need set forth in the State Health
2319 Plan, as identified in Section 41-7-171 et seq.
2320 This subsection (13) shall stand repealed from and after July
2321 1, 2005.
2322 (14) The State Department of Health shall issue a
2323 certificate of need to any hospital which is currently licensed
2324 for two hundred fifty (250) or more acute care beds and is located
2325 in any general hospital service area not having a comprehensive
2326 cancer center, for the establishment and equipping of such a
2327 center which provides facilities and services for outpatient
2328 radiation oncology therapy, outpatient medical oncology therapy,
2329 and appropriate support services including the provision of
2330 radiation therapy services. The provision of Section 41-7-193(1)
2331 regarding substantial compliance with the projection of need as
2332 reported in the current State Health Plan is waived for the
2333 purpose of this subsection.
2334 (15) The State Department of Health may authorize the
2335 transfer of hospital beds, not to exceed sixty (60) beds, from the
2336 North Panola Community Hospital to the South Panola Community
2337 Hospital. The authorization for the transfer of those beds shall
2338 be exempt from the certificate of need review process.
2339 (16) Nothing in this section or in any other provision of
2340 Section 41-7-171 et seq. shall prevent any nursing facility from
2341 designating an appropriate number of existing beds in the facility
2342 as beds for providing care exclusively to patients with
2343 Alzheimer's disease.

2344 (17) Beginning July 1, 2003, and annually thereafter, the
2345 State Department of Health shall revise the State Health Plan to
2346 include home- and community-based services located in the health
2347 service districts as authorized alternatives to institutional
2348 nursing facility services in determining the need for additional
2349 nursing facility beds.

2350 **SECTION 7.** This act shall take effect and be in force from
2351 and after its passage.

ST: Medicaid; revise eligibility and services, and prohibit CONs for certain facilities.