

By: Senator(s) Huggins, Gordon, Little,
Burton, Harden

To: Public Health and
Welfare; Appropriations

COMMITTEE SUBSTITUTE
FOR
SENATE BILL NO. 2346

1 AN ACT RELATIVE TO THE MISSISSIPPI MEDICAID ASSISTANCE
2 PROGRAM; TO AMEND SECTION 43-13-113, MISSISSIPPI CODE OF 1972, TO
3 AUTHORIZE THE DIVISION OF MEDICAID TO OBTAIN A LINE OF CREDIT FROM
4 THE WORKING CASH-STABILIZATION FUND OR OTHER SPECIAL SOURCE FUNDS
5 FOR BUDGET SHORTFALLS; TO AMEND SECTION 43-13-115, MISSISSIPPI
6 CODE OF 1972, TO CLARIFY ELIGIBILITY FOR MEDICAID ASSISTANCE, TO
7 AUTHORIZE THE DIVISION OF MEDICAID TO APPLY FOR APPLICABLE WAIVERS
8 FOR BENEFITS AND BUY-IN OPTIONS FOR THE DISABLED CHILDREN LIVING
9 AT HOME AND POVERTY LEVEL AGED AND DISABLED (PLADS) ELIGIBILITY
10 CATEGORIES AND TO ESTABLISH AN EXPENDITURE/ENROLLMENT CAP FOR
11 THESE CATEGORIES; TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF
12 1972, TO REDUCE THE NURSING FACILITY BED DAYS ELIGIBLE FOR
13 MEDICAID REIMBURSEMENT, TO AUTHORIZE THE DIVISION TO DEVELOP AN
14 ASSESSMENT PROCESS FOR LONG-TERM CARE SERVICES AND DELETE THE
15 REFERRAL PHYSICIAN CERTIFICATION PROCESS, TO DELETE THE NECESSITY
16 TO COMPARE HOME HEALTH COSTS TO NURSING FACILITY SERVICES FOR
17 REIMBURSEMENT, TO DELETE AUTHORITY FOR THE DIVISION TO OPT OUT OF
18 THE FEDERAL DRUG REBATE PROGRAM AND CREATE A CLOSED DRUG
19 FORMULARY, TO DIRECT THE DIVISION TO IMPLEMENT A PREFERRED DRUG
20 LIST (PDL), TO DIRECT THE DIVISION TO DEVELOP A STATE MAXIMUM
21 ALLOWABLE COST (MAC) PRICING SCHEDULE FOR DRUG REIMBURSEMENT, TO
22 DELETE PRIOR APPROVAL OF MONTHLY DRUG PRESCRIPTIONS OVER FIVE, TO
23 PROVIDE THAT CERTAIN ANTIPSYCHOTIC DRUGS SHALL BE INCLUDED IN ANY
24 PREFERRED DRUG LIST DEVELOPED BY THE DIVISION OF MEDICAID AND
25 SHALL NOT REQUIRE PRIOR AUTHORIZATION FOR MEDICAID REIMBURSEMENT,
26 TO ALLOW A DISPENSING FEE FOR OVER-THE-COUNTER DRUGS, TO REDUCE
27 THE ICF/MR BED DAYS ELIGIBLE FOR REIMBURSEMENT, TO DELETE CERTAIN
28 RESTRICTIONS ON THE HOME- AND COMMUNITY-BASED SERVICES WAIVER
29 PROGRAM, TO DIRECT THE DIVISION TO PAY A FLAT FEE FOR NONEMERGENCY
30 TRANSPORTATION SERVICES OR IN THE ALTERNATIVE REIMBURSE ACTUAL
31 MILES TRAVELED AND TO APPLY FOR WAIVERS TO DRAW FEDERAL FUNDS FOR
32 NONEMERGENCY TRANSPORTATION AS A COVERED SERVICE, TO DELETE THE
33 AUTHORITY FOR REIMBURSEMENT FOR BIRTHING CENTER SERVICES, TO
34 CLARIFY THE ASSISTED LIVING SERVICES WAIVER PROVISION, TO GIVE THE
35 DIVISION DISCRETION IN PAYING MEDICARE COINSURANCE AMOUNTS, TO
36 AUTHORIZE CHILDREN UP TO TWO YEARS OF AGE FOR THE OBSTETRICAL CARE
37 WAIVER PROGRAM, TO DELETE CERTAIN RESTRICTIONS IN THE DISEASE
38 MANAGEMENT PROGRAM AUTHORITY, TO REMOVE THE 5% REIMBURSEMENT
39 REDUCTION FOR CASE MANAGEMENT SERVICES UNDER THE HOME- AND
40 COMMUNITY-BASED PROGRAM PROVIDED BY A PLANNING AND DEVELOPMENT
41 DISTRICT (PDD) AND TO PRESCRIBE A RATE OF REIMBURSEMENT FOR SUCH
42 SERVICES AND A FUNDS TRANSFER REQUIREMENT, AND TO AUTHORIZE THE
43 DIVISION TO REMOVE THE 5% REDUCTION IN REIMBURSEMENT FOR PROVIDERS
44 WHO PARTICIPATE IN THE EMERGENCY ROOM REDIRECTION PROGRAM; TO
45 AMEND SECTION 43-13-122, MISSISSIPPI CODE OF 1972, TO DELETE
46 CERTAIN OBSOLETE LANGUAGE; TO AMEND SECTION 43-13-107, MISSISSIPPI
47 CODE OF 1972, TO AUTHORIZE THE DIVISION TO SUBMIT EMERGENCY DRUG
48 ISSUES TO THE PHARMACY AND THERAPEUTICS COMMITTEE WITHOUT PUBLIC
49 COMMENT; TO AMEND SECTION 43-13-145, MISSISSIPPI CODE OF 1972, TO
50 INCREASE THE PER BED ASSESSMENT LEVIED UPON NURSING FACILITIES FOR
51 SUPPORT OF THE MEDICAID PROGRAM; TO AMEND SECTION 41-7-191,
52 MISSISSIPPI CODE OF 1972, TO PROHIBIT THE STATE DEPARTMENT OF



53 HEALTH FROM ISSUING A CERTIFICATE OF NEED FOR THE ADDITION,
54 CONSTRUCTION OR CONVERSION OF ANY NURSING FACILITY BEDS AFTER THE
55 EFFECTIVE DATE OF THIS ACT, AND TO INCLUDE HOME- AND
56 COMMUNITY-BASED SERVICES IN THE STATE HEALTH PLAN FOR LONG-TERM
57 CARE CON PURPOSES; AND FOR RELATED PURPOSES.

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

59 **SECTION 1.** Section 43-13-113, Mississippi Code of 1972, is
60 amended as follows:

61 43-13-113. (1) The State Treasurer shall receive on behalf
62 of the state, and execute all instruments incidental thereto,
63 federal and other funds to be used for financing the medical
64 assistance plan or program adopted pursuant to this article, and
65 place all such funds in a special account to the credit of the
66 Governor's Office-Division of Medicaid, which funds shall be
67 expended by the division for the purposes and under the provisions
68 of this article, and shall be paid out by the State Treasurer as
69 funds appropriated to carry out the provisions of this article are
70 paid out by him.

71 The division shall issue all checks or electronic transfers
72 for administrative expenses, and for medical assistance under the
73 provisions of this article. All such checks or electronic
74 transfers shall be drawn upon funds made available to the division
75 by the State Auditor, upon requisition of the director. It is the
76 purpose of this section to provide that the State Auditor shall
77 transfer, in lump sums, amounts to the division for disbursement
78 under the regulations which shall be made by the director with the
79 approval of the Governor; however, the division, or its fiscal
80 agent in behalf of the division, shall be authorized in
81 maintaining separate accounts with a Mississippi bank to handle
82 claim payments, refund recoveries and related Medicaid program
83 financial transactions, to aggressively manage the float in these
84 accounts while awaiting clearance of checks or electronic
85 transfers and/or other disposition so as to accrue maximum
86 interest advantage of the funds in the account, and to retain all



87 earned interest on these funds to be applied to match federal
88 funds for Medicaid program operations.

89 (2) The division is authorized to obtain a line of credit
90 through the State Treasurer from the Working Cash-Stabilization
91 Fund or any other special source funds maintained in the State
92 Treasury in an amount not exceeding Ten Million Dollars
93 (\$10,000,000.00) to fund shortfalls which, from time to time, may
94 occur due to decreases in state matching fund cash flow. The
95 length of indebtedness under this provision shall not carry past
96 the end of the quarter following the loan origination. Loan
97 proceeds shall be received by the State Treasurer and shall be
98 placed in a Medicaid designated special fund account. Loan
99 proceeds shall be expended only for health care services provided
100 under the Medicaid program. The division may pledge as security
101 for such interim financing future funds that will be received by
102 the division. Any such loans shall be repaid from the first
103 available funds received by the division in the manner of and
104 subject to the same terms provided in this section.

105 (3) Disbursement of funds to providers shall be made as
106 follows:

107 (a) All providers must submit all claims to the
108 Division of Medicaid's fiscal agent no later than twelve (12)
109 months from the date of service.

110 (b) The Division of Medicaid's fiscal agent must pay
111 ninety percent (90%) of all clean claims within thirty (30) days
112 of the date of receipt.

113 (c) The Division of Medicaid's fiscal agent must pay
114 ninety-nine percent (99%) of all clean claims within ninety (90)
115 days of the date of receipt.

116 (d) The Division of Medicaid's fiscal agent must pay
117 all other claims within twelve (12) months of the date of receipt.

118 (e) If a claim is neither paid nor denied for valid and
119 proper reasons by the end of the time periods as specified above,



120 the Division of Medicaid's fiscal agent must pay the provider
121 interest on the claim at the rate of one and one-half percent
122 (1-1/2%) per month on the amount of such claim until it is finally
123 settled or adjudicated.

124 (4) The date of receipt is the date the fiscal agent
125 receives the claim as indicated by its date stamp on the claim or,
126 for those claims filed electronically, the date of receipt is the
127 date of transmission.

128 (5) The date of payment is the date of the check or, for
129 those claims paid by electronic funds transfer, the date of the
130 transfer.

131 (6) The above specified time limitations do not apply in the
132 following circumstances:

133 (a) Retroactive adjustments paid to providers
134 reimbursed under a retrospective payment system;

135 (b) If a claim for payment under Medicare has been
136 filed in a timely manner, the fiscal agent may pay a Medicaid
137 claim relating to the same services within six (6) months after
138 it, or the provider, receives notice of the disposition of the
139 Medicare claim;

140 (c) Claims from providers under investigation for fraud
141 or abuse; and

142 (d) The Division of Medicaid and/or its fiscal agent
143 may make payments at any time in accordance with a court order, to
144 carry out hearing decisions or corrective actions taken to resolve
145 a dispute, or to extend the benefits of a hearing decision,
146 corrective action, or court order to others in the same situation
147 as those directly affected by it.

148 (7) Repealed.

149 (8) If sufficient funds are appropriated therefor by the
150 Legislature, the Division of Medicaid may contract with the
151 Mississippi Dental Association, or an approved designee, to
152 develop and operate a Donated Dental Services (DDS) program



153 through which volunteer dentists will treat needy disabled, aged
154 and medically-compromised individuals who are non-Medicaid
155 eligible recipients.

156 **SECTION 2.** Section 43-13-115, Mississippi Code of 1972, is
157 amended as follows:

158 43-13-115. Recipients of medical assistance shall be the
159 following persons only:

160 (1) Who are qualified for public assistance grants
161 under provisions of Title IV-A and E of the federal Social
162 Security Act, as amended, as determined by the State Department of
163 Human Services, including those statutorily deemed to be IV-A and
164 low-income families and children under Section 1931 of the Social
165 Security Act as determined by the State Department of Human
166 Services and certified to the Division of Medicaid, but not
167 optional groups except as specifically covered in this section.
168 For the purposes of this paragraph (1) and paragraphs (8), (17)
169 and (18) of this section, any reference to Title IV-A or to Part A
170 of Title IV of the federal Social Security Act, as amended, or the
171 state plan under Title IV-A or Part A of Title IV, shall be
172 considered as a reference to Title IV-A of the federal Social
173 Security Act, as amended, and the state plan under Title IV-A,
174 including the income and resource standards and methodologies
175 under Title IV-A and the state plan, as they existed on July 16,
176 1996.

177 (2) Those qualified for Supplemental Security Income
178 (SSI) benefits under Title XVI of the federal Social Security Act,
179 as amended, and those who are deemed SSI eligible as contained in
180 federal statute. The eligibility of individuals covered in this
181 paragraph shall be determined by the Social Security
182 Administration and certified to the Division of Medicaid.

183 (3) Qualified pregnant women who would be eligible for
184 medical assistance as a low income family member under Section
185 1931 of the Social Security Act if her child was born.



186 (4) [Deleted]

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

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

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



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

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

229 (9) Individuals who are:

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

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

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

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

245 (10) Certain disabled children age eighteen (18) or
246 under who are living at home, who would be eligible, if in a
247 medical institution, for SSI or a state supplemental payment under
248 Title XVI of the federal Social Security Act, as amended, and
249 therefore for Medicaid under the plan, and for whom the state has
250 made a determination as required under Section 1902(e)(3)(b) of



251 the federal Social Security Act, as amended. The eligibility of
252 individuals under this paragraph shall be determined by the
253 Division of Medicaid; provided, however, that the division may
254 apply to the Center for Medicare and Medicaid Services (CMS) for a
255 waiver that will allow flexibility in the benefit design for the
256 Disabled Children Living at Home eligibility category authorized
257 herein, and the division may establish an expenditure/enrollment
258 cap for this category. Nothing contained in this paragraph (10)
259 shall entitle an individual for benefits.

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

267 The eligibility of individuals covered under this paragraph
268 shall be determined by the Division of Medicaid; provided,
269 however, that the division may apply to the Center for Medicare
270 and Medicaid Services (CMS) for a waiver that will allow
271 flexibility in the benefit design and buy-in options for the
272 Poverty Level Aged and Disabled (PLAD) eligibility category
273 authorized herein, and the division may establish an
274 expenditure/enrollment cap for this category. Nothing contained
275 in this paragraph (11) shall entitle an individual for benefits.

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



283 The eligibility of individuals covered under this paragraph
284 shall be determined by the Division of Medicaid, and such
285 individuals determined eligible shall receive Medicare
286 cost-sharing expenses only as more fully defined by the Medicare
287 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
288 1997.

289 (13) * * * Individuals who are entitled to Medicare
290 Part A as defined in Section 4501 of the Omnibus Budget
291 Reconciliation Act of 1990, and whose income does not exceed one
292 hundred twenty percent (120%) of the nonfarm official poverty line
293 as defined by the Office of Management and Budget and revised
294 annually. Eligibility for Medicaid benefits is limited to full
295 payment of Medicare Part B premiums.

296 * * *

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

299 (14) [Deleted]

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

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



315 (17) In accordance with the terms of the federal
316 Personal Responsibility and Work Opportunity Reconciliation Act of
317 1996 (Public Law 104-193), persons who become ineligible for
318 assistance under Title IV-A of the federal Social Security Act, as
319 amended, because of increased income from or hours of employment
320 of the caretaker relative or because of the expiration of the
321 applicable earned income disregards, who were eligible for
322 Medicaid for at least three (3) of the six (6) months preceding
323 the month in which such ineligibility begins, shall be eligible
324 for Medicaid assistance for up to twelve (12) months * * *.

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

334 (19) Disabled workers, whose incomes are above the
335 Medicaid eligibility limits, but below two hundred fifty percent
336 (250%) of the federal poverty level, shall be allowed to purchase
337 Medicaid coverage on a sliding fee scale developed by the Division
338 of Medicaid.

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

344 (21) Women of childbearing age whose family income does
345 not exceed one hundred eighty-five percent (185%) of the federal
346 poverty level. The eligibility of individuals covered under this
347 paragraph (21) shall be determined by the Division of Medicaid,



348 and those individuals determined eligible shall only receive
349 family planning services covered under Section 43-13-117(13) and
350 not any other services covered under Medicaid. However, any
351 individual eligible under this paragraph (21) who is also eligible
352 under any other provision of this section shall receive the
353 benefits to which he or she is entitled under that other
354 provision, in addition to family planning services covered under
355 Section 43-13-117(13).

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

364 (22) Persons who are workers with a potentially severe
365 disability, as determined by the division, shall be allowed to
366 purchase Medicaid coverage. The term "worker with a potentially
367 severe disability" means a person who is at least sixteen (16)
368 years of age but under sixty-five (65) years of age, who has a
369 physical or mental impairment that is reasonably expected to cause
370 the person to become blind or disabled as defined under Section
371 1614(a) of the federal Social Security Act, as amended, if the
372 person does not receive items and services provided under
373 Medicaid.

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



381 * * *

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

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

398 * * *

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

401 43-13-117. Medicaid as authorized by this article shall
402 include payment of part or all of the costs, at the discretion of
403 the division or its successor, with approval of the Governor, of
404 the following types of care and services rendered to eligible
405 applicants who have been determined to be eligible for that care
406 and services, within the limits of state appropriations and
407 federal matching funds:

408 (1) Inpatient hospital services.

409 (a) The division shall allow thirty (30) days of
410 inpatient hospital care annually for all Medicaid recipients.
411 Precertification of inpatient days must be obtained as required by
412 the division. The division may allow unlimited days in
413 disproportionate hospitals as defined by the division for eligible



414 infants under the age of six (6) years if certified as medically
415 necessary as required by the division.

416 (b) From and after July 1, 1994, the Executive
417 Director of the Division of Medicaid shall amend the Mississippi
418 Title XIX Inpatient Hospital Reimbursement Plan to remove the
419 occupancy rate penalty from the calculation of the Medicaid
420 Capital Cost Component utilized to determine total hospital costs
421 allocated to the Medicaid program.

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

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

434 (3) Laboratory and x-ray services.

435 (4) Nursing facility services.

436 (a) The division shall make full payment to
437 nursing facilities for each day, not exceeding thirty (30) days
438 per year, that a patient is absent from the facility on home
439 leave. Payment may be made for the following home leave days in
440 addition to the thirty-day limitation: Christmas, the day before
441 Christmas, the day after Christmas, Thanksgiving, the day before
442 Thanksgiving and the day after Thanksgiving.

443 (b) From and after July 1, 1997, the division
444 shall implement the integrated case-mix payment and quality
445 monitoring system, which includes the fair rental system for
446 property costs and in which recapture of depreciation is



447 eliminated. The division may reduce the payment for hospital
448 leave and therapeutic home leave days to the lower of the case-mix
449 category as computed for the resident on leave using the
450 assessment being utilized for payment at that point in time, or a
451 case-mix score of 1.000 for nursing facilities, and shall compute
452 case-mix scores of residents so that only services provided at the
453 nursing facility are considered in calculating a facility's per
454 diem.

455 During the period between May 1, 2002, and December 1, 2002,
456 the Chairmen of the Public Health and Welfare Committees of the
457 Senate and the House of Representatives may appoint a joint study
458 committee to consider the issue of setting uniform reimbursement
459 rates for nursing facilities. The study committee will consist of
460 the Chairmen of the Public Health and Welfare Committees, three
461 (3) members of the Senate and three (3) members of the House. The
462 study committee shall complete its work in not more than three (3)
463 meetings.

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

467 (d) When a facility of a category that does not
468 require a certificate of need for construction and that could not
469 be eligible for Medicaid reimbursement is constructed to nursing
470 facility specifications for licensure and certification, and the
471 facility is subsequently converted to a nursing facility under a
472 certificate of need that authorizes conversion only and the
473 applicant for the certificate of need was assessed an application
474 review fee based on capital expenditures incurred in constructing
475 the facility, the division shall allow reimbursement for capital
476 expenditures necessary for construction of the facility that were
477 incurred within the twenty-four (24) consecutive calendar months
478 immediately preceding the date that the certificate of need
479 authorizing the conversion was issued, to the same extent that



480 reimbursement would be allowed for construction of a new nursing
481 facility under a certificate of need that authorizes that
482 construction. The reimbursement authorized in this subparagraph
483 (d) may be made only to facilities the construction of which was
484 completed after June 30, 1989. Before the division shall be
485 authorized to make the reimbursement authorized in this
486 subparagraph (d), the division first must have received approval
487 from the Health Care Financing Administration of the United States
488 Department of Health and Human Services of the change in the state
489 Medicaid plan providing for the reimbursement.

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

503 (f) The division shall develop and implement an
504 assessment process for long-term care services.

505 * * *

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

510 (5) Periodic screening and diagnostic services for
511 individuals under age twenty-one (21) years as are needed to
512 identify physical and mental defects and to provide health care



513 treatment and other measures designed to correct or ameliorate
514 defects and physical and mental illness and conditions discovered
515 by the screening services regardless of whether these services are
516 included in the state plan. The division may include in its
517 periodic screening and diagnostic program those discretionary
518 services authorized under the federal regulations adopted to
519 implement Title XIX of the federal Social Security Act, as
520 amended. The division, in obtaining physical therapy services,
521 occupational therapy services, and services for individuals with
522 speech, hearing and language disorders, may enter into a
523 cooperative agreement with the State Department of Education for
524 the provision of those services to handicapped students by public
525 school districts using state funds that are provided from the
526 appropriation to the Department of Education to obtain federal
527 matching funds through the division. The division, in obtaining
528 medical and psychological evaluations for children in the custody
529 of the State Department of Human Services may enter into a
530 cooperative agreement with the State Department of Human Services
531 for the provision of those services using state funds that are
532 provided from the appropriation to the Department of Human
533 Services to obtain federal matching funds through the division.

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



546 which shall in no event be less than seventy percent (70%) of the
547 adjusted Medicare payment established on January 1, 1994.

548 (7) (a) Home health services for eligible
549 persons, * * * not to exceed sixty (60) visits per year. All home
550 health visits must be precertified as required by the division.

551 (b) Repealed.

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

563 (9) (a) Legend and other drugs as may be determined by
564 the division. The division shall contract for full scope pharmacy
565 benefit management services and shall implement a preferred drug
566 list (PDL). The division may implement a program of prior
567 approval for drugs to the extent permitted by law. The division
568 shall allow seven (7) prescriptions per month for each
569 noninstitutionalized Medicaid recipient. * * * The division shall
570 not reimburse for any portion of a prescription that exceeds a
571 thirty-four-day supply of the drug based on the daily dosage.

572 * * *

573 Provided, however, that any A-typical antipsychotic drug
574 shall be included in any preferred drug list developed by the
575 Division of Medicaid and shall not require prior authorization,
576 and any licensed physician may prescribe any A-typical
577 antipsychotic drug deemed appropriate for Medicaid recipients
578 which shall be fully eligible for Medicaid reimbursement.



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

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

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

592 (b) * * * Payment by the division for covered
593 multiple source drugs shall be limited to the lower of the upper
594 limits established and published by the Centers for Medicare and
595 Medicaid Services (CMS) plus a dispensing fee, or the estimated
596 acquisition cost (EAC) plus a dispensing fee, or the providers'
597 usual and customary charge to the general public. * * *

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

602 Payment for nonlegend or over-the-counter drugs covered by
603 the division * * * shall be reimbursed at the lower of the
604 division's estimated shelf price or the providers' usual and
605 customary charge to the general public. * * *

606 The dispensing fee for each new or refill prescription,
607 including nonlegend or over-the-counter drugs covered by the
608 division, shall be Three Dollars and Ninety-one Cents (\$3.91).

609 The Medicaid provider shall not prescribe, the Medicaid
610 pharmacy shall not bill, and the division shall not reimburse for
611 name brand drugs if there are equally effective generic



612 equivalents available and if the generic equivalents are the least
613 expensive.

614 * * *

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

618 The division shall develop a state Maximum Allowable Cost
619 (MAC) pricing schedule for selected drugs in order to reduce the
620 cost of the pharmacy program as soon as practicable.

621 * * *

622 (10) Dental care that is an adjunct to treatment of an
623 acute medical or surgical condition; services of oral surgeons and
624 dentists in connection with surgery related to the jaw or any
625 structure contiguous to the jaw or the reduction of any fracture
626 of the jaw or any facial bone; and emergency dental extractions
627 and treatment related thereto. On July 1, 1999, all fees for
628 dental care and surgery under authority of this paragraph (10)
629 shall be increased to one hundred sixty percent (160%) of the
630 amount of the reimbursement rate that was in effect on June 30,
631 1999. It is the intent of the Legislature to encourage more
632 dentists to participate in the Medicaid program.

633 (11) Eyeglasses for all Medicaid beneficiaries who have
634 (a) had surgery on the eyeball or ocular muscle that results in a
635 vision change for which eyeglasses or a change in eyeglasses is
636 medically indicated within six (6) months of the surgery and is in
637 accordance with policies established by the division, or (b) one
638 (1) pair every five (5) years and in accordance with policies
639 established by the division. In either instance, the eyeglasses
640 must be prescribed by a physician skilled in diseases of the eye
641 or an optometrist, whichever the beneficiary may select.

642 (12) Intermediate care facility services.

643 (a) The division shall make full payment to all
644 intermediate care facilities for the mentally retarded for each



645 day, not exceeding sixty (60) days per year, that a patient is
646 absent from the facility on home leave. Payment may be made for
647 the following home leave days in addition to the sixty-day
648 limitation: Christmas, the day before Christmas, the day after
649 Christmas, Thanksgiving, the day before Thanksgiving and the day
650 after Thanksgiving.

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

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

657 (14) Clinic services. Such diagnostic, preventive,
658 therapeutic, rehabilitative or palliative services furnished to an
659 outpatient by or under the supervision of a physician or dentist
660 in a facility that is not a part of a hospital but that is
661 organized and operated to provide medical care to outpatients.
662 Clinic services shall include any services reimbursed as
663 outpatient hospital services that may be rendered in such a
664 facility, including those that become so after July 1, 1991. On
665 July 1, 1999, all fees for physicians' services reimbursed under
666 authority of this paragraph (14) shall be reimbursed at ninety
667 percent (90%) of the rate established on January 1, 1999, and as
668 adjusted each January thereafter, under Medicare (Title XVIII of
669 the Social Security Act, as amended), and which shall in no event
670 be less than seventy percent (70%) of the rate established on
671 January 1, 1994. All fees for physicians' services that are
672 covered by both Medicare and Medicaid shall be reimbursed at ten
673 percent (10%) of the adjusted Medicare payment established on
674 January 1, 1999, and as adjusted each January thereafter, under
675 Medicare (Title XVIII of the Social Security Act, as amended), and
676 which shall in no event be less than seventy percent (70%) of the
677 adjusted Medicare payment established on January 1, 1994. On July



678 1, 1999, all fees for dentists' services reimbursed under
679 authority of this paragraph (14) shall be increased to one hundred
680 sixty percent (160%) of the amount of the reimbursement rate that
681 was in effect on June 30, 1999.

682 (15) Home- and community-based services for the elderly
683 and disabled, as provided under Title XIX of the federal Social
684 Security Act, as amended, under waivers, subject to the
685 availability of funds specifically appropriated therefor by the
686 Legislature. * * *

687 (16) Mental health services. Approved therapeutic and
688 case management services (a) provided by an approved regional
689 mental health/retardation center established under Sections
690 41-19-31 through 41-19-39, or by another community mental health
691 service provider meeting the requirements of the Department of
692 Mental Health to be an approved mental health/retardation center
693 if determined necessary by the Department of Mental Health, using
694 state funds that are provided from the appropriation to the State
695 Department of Mental Health and/or funds transferred to the
696 department by a political subdivision or instrumentality of the
697 state and used to match federal funds under a cooperative
698 agreement between the division and the department, or (b) provided
699 by a facility that is certified by the State Department of Mental
700 Health to provide therapeutic and case management services, to be
701 reimbursed on a fee for service basis, or (c) provided in the
702 community by a facility or program operated by the Department of
703 Mental Health. Any such services provided by a facility described
704 in subparagraph (b) must have the prior approval of the division
705 to be reimbursable under this section. After June 30, 1997,
706 mental health services provided by regional mental
707 health/retardation centers established under Sections 41-19-31
708 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
709 and/or their subsidiaries and divisions, or by psychiatric
710 residential treatment facilities as defined in Section 43-11-1, or



711 by another community mental health service provider meeting the
712 requirements of the Department of Mental Health to be an approved
713 mental health/retardation center if determined necessary by the
714 Department of Mental Health, shall not be included in or provided
715 under any capitated managed care pilot program provided for under
716 paragraph (24) of this section.

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

723 (18) (a) Notwithstanding any other provision of this
724 section to the contrary, the division shall make additional
725 reimbursement to hospitals that serve a disproportionate share of
726 low-income patients and that meet the federal requirements for
727 those payments as provided in Section 1923 of the federal Social
728 Security Act and any applicable regulations. However, from and
729 after January 1, 1999, no public hospital shall participate in the
730 Medicaid disproportionate share program unless the public hospital
731 participates in an intergovernmental transfer program as provided
732 in Section 1903 of the federal Social Security Act and any
733 applicable regulations. Administration and support for
734 participating hospitals shall be provided by the Mississippi
735 Hospital Association.

736 (b) The division shall establish a Medicare Upper
737 Payment Limits Program, as defined in Section 1902(a)(30) of the
738 federal Social Security Act and any applicable federal
739 regulations, for hospitals, and may establish a Medicare Upper
740 Payments Limits Program for nursing facilities. The division
741 shall assess each hospital and, if the program is established for
742 nursing facilities, shall assess each nursing facility, for the
743 sole purpose of financing the state portion of the Medicare Upper



744 Payment Limits Program. This assessment shall be based on
745 Medicaid utilization, or other appropriate method consistent with
746 federal regulations, and will remain in effect as long as the
747 state participates in the Medicare Upper Payment Limits Program.
748 The division shall make additional reimbursement to hospitals and,
749 if the program is established for nursing facilities, shall make
750 additional reimbursement to nursing facilities, for the Medicare
751 Upper Payment Limits, as defined in Section 1902(a)(30) of the
752 federal Social Security Act and any applicable federal
753 regulations. This subparagraph (b) shall stand repealed from and
754 after July 1, 2005.

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

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

770 (b) Early intervention system services. The
771 division shall cooperate with the State Department of Health,
772 acting as lead agency, in the development and implementation of a
773 statewide system of delivery of early intervention services, under
774 Part C of the Individuals with Disabilities Education Act (IDEA).
775 The State Department of Health shall certify annually in writing
776 to the executive director of the division the dollar amount of



777 state early intervention funds available that will be utilized as
778 a certified match for Medicaid matching funds. Those funds then
779 shall be used to provide expanded targeted case management
780 services for Medicaid eligible children with special needs who are
781 eligible for the state's early intervention system.

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

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

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

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



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

822 (24) [Deleted]

823 (25) [Deleted]

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

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

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



842 (29) The Division of Medicaid may apply for a waiver
843 from the Department of Health and Human Services for home- and
844 community-based services for developmentally disabled people using
845 state funds that are provided from the appropriation to the State
846 Department of Mental Health and/or funds transferred to the
847 department by a political subdivision or instrumentality of the
848 state and used to match federal funds under a cooperative
849 agreement between the division and the department, provided that
850 funds for these services are specifically appropriated to the
851 Department of Mental Health and/or transferred to the department
852 by a political subdivision or instrumentality of the state.

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

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

861 (32) Care and services provided in Christian Science
862 Sanatoria listed and certified by the Commission for Accreditation
863 of Christian Science Nursing Organizations/Facilities, Inc.,
864 rendered in connection with treatment by prayer or spiritual means
865 to the extent that those services are subject to reimbursement
866 under Section 1903 of the Social Security Act.

867 (33) Podiatrist services.

868 (34) Assisted living services as provided through home-
869 and community-based services under Title XIX of the Social
870 Security Act, as amended, subject to the availability of funds
871 specifically appropriated therefor by the Legislature.

872 (35) Services and activities authorized in Sections
873 43-27-101 and 43-27-103, using state funds that are provided from
874 the appropriation to the State Department of Human Services and



875 used to match federal funds under a cooperative agreement between
876 the division and the department.

877 (36) Nonemergency transportation services for
878 Medicaid-eligible persons, to be provided by the Division of
879 Medicaid. The division may contract with additional entities to
880 administer nonemergency transportation services as it deems
881 necessary. All providers shall have a valid driver's license,
882 vehicle inspection sticker, valid vehicle license tags and a
883 standard liability insurance policy covering the vehicle. The
884 division may pay providers a flat fee based on mileage tiers, or
885 in the alternative, may reimburse on actual miles traveled. The
886 division may apply to the Center for Medicare and Medicaid
887 Services (CMS) for a waiver to draw federal matching funds for
888 nonemergency transportation services as a covered service instead
889 of an administrative cost.

890 (37) [Deleted]

891 (38) Chiropractic services. A chiropractor's manual
892 manipulation of the spine to correct a subluxation, if x-ray
893 demonstrates that a subluxation exists and if the subluxation has
894 resulted in a neuromusculoskeletal condition for which
895 manipulation is appropriate treatment, and related spinal x-rays
896 performed to document these conditions. Reimbursement for
897 chiropractic services shall not exceed Seven Hundred Dollars
898 (\$700.00) per year per beneficiary.

899 (39) Dually eligible Medicare/Medicaid beneficiaries.
900 The division shall pay the Medicare deductible and * * *
901 coinsurance amounts for services available under Medicare, as
902 determined by the division.

903 (40) [Deleted]

904 (41) Services provided by the State Department of
905 Rehabilitation Services for the care and rehabilitation of persons
906 with spinal cord injuries or traumatic brain injuries, as allowed
907 under waivers from the United States Department of Health and



908 Human Services, using up to seventy-five percent (75%) of the
909 funds that are appropriated to the Department of Rehabilitation
910 Services from the Spinal Cord and Head Injury Trust Fund
911 established under Section 37-33-261 and used to match federal
912 funds under a cooperative agreement between the division and the
913 department.

914 (42) Notwithstanding any other provision in this
915 article to the contrary, the division may develop a population
916 health management program for women and children health services
917 through the age of one (1) year. This program is primarily for
918 obstetrical care associated with low birth weight and pre-term
919 babies. The division may apply to the federal Centers for
920 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
921 any other waivers that may enhance the program. In order to
922 effect cost savings, the division may develop a revised payment
923 methodology that may include at-risk capitated payments, and may
924 require member participation in accordance with the terms and
925 conditions of an approved federal waiver.

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

931 (44) Nursing facility services for the severely
932 disabled.

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

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



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

947 (46) The division shall make application to the federal
948 Centers for Medicare and Medicaid Services (CMS) for a waiver to
949 develop and provide services for children with serious emotional
950 disturbances as defined in Section 43-14-1(1), which may include
951 home- and community-based services, case management services or
952 managed care services through mental health providers certified by
953 the Department of Mental Health. The division may implement and
954 provide services under this waived program only if funds for
955 these services are specifically appropriated for this purpose by
956 the Legislature, or if funds are voluntarily provided by affected
957 agencies.

958 (47) Notwithstanding any other provision in this
959 article to the contrary, the division * * * shall develop and
960 implement disease management programs * * *.

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

962 (a) Pediatric long-term acute care hospital
963 services means services provided to eligible persons under
964 twenty-one (21) years of age by a freestanding Medicare-certified
965 hospital that has an average length of inpatient stay greater than
966 twenty-five (25) days and that is primarily engaged in providing
967 chronic or long-term medical care to persons under twenty-one (21)
968 years of age.

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

971 (49) The division shall establish copayments for all
972 Medicaid services for which copayments are allowable under federal



973 law or regulation, except for nonemergency transportation
974 services, and shall set the amount of the copayment for each of
975 those services at the maximum amount allowable under federal law
976 or regulation.

977 Notwithstanding any other provision of this article to the
978 contrary, the division shall reduce the rate of reimbursement to
979 providers for any service provided under this section by five
980 percent (5%) of the allowed amount for that service. However, the
981 reduction in the reimbursement rates required by this paragraph
982 shall not apply to inpatient hospital services, nursing facility
983 services, intermediate care facility services, psychiatric
984 residential treatment facility services, pharmacy services
985 provided under paragraph (9) of this section, or any service
986 provided by the University of Mississippi Medical Center or a
987 state agency, a state facility or a public agency that either
988 provides its own state match through intergovernmental transfer or
989 certification of funds to the division, or a service for which the
990 federal government sets the reimbursement methodology and rate.
991 In addition, the reduction in the reimbursement rates required by
992 this paragraph shall not apply to case management services * * *
993 provided under the home- and community-based services program for
994 the elderly and disabled by a planning and development district
995 (PDD). Planning and development districts participating in the
996 home- and community-based services program for the elderly and
997 disabled as case management providers shall be reimbursed for case
998 management services at the maximum rate approved by the Centers
999 for Medicare and Medicaid Services (CMS). PDDs shall transfer to
1000 the division state match from public funds (not federal) in an
1001 amount equal to the difference between the maximum case management
1002 reimbursement rate approved by CMS and a five percent (5%)
1003 reduction in that rate. The division shall invoice each PDD
1004 fifteen (15) days after the end of each quarter for said



1005 intergovernmental transfer based on the number of Medicaid home-
1006 and community-based clients the PDD served during the quarter.

1007 The division may remove the five percent (5%) reduction in
1008 reimbursement for those providers who participate in the
1009 division's emergency room redirection program and achieve the
1010 performance measures and reduction of costs required of that
1011 program.

1012 Notwithstanding any provision of this article, except as
1013 authorized in the following paragraph and in Section 43-13-139,
1014 neither (a) the limitations on quantity or frequency of use of or
1015 the fees or charges for any of the care or services available to
1016 recipients under this section, nor (b) the payments or rates of
1017 reimbursement to providers rendering care or services authorized
1018 under this section to recipients, may be increased, decreased or
1019 otherwise changed from the levels in effect on July 1, 1999,
1020 unless they are authorized by an amendment to this section by the
1021 Legislature. However, the restriction in this paragraph shall not
1022 prevent the division from changing the payments or rates of
1023 reimbursement to providers without an amendment to this section
1024 whenever those changes are required by federal law or regulation,
1025 or whenever those changes are necessary to correct administrative
1026 errors or omissions in calculating those payments or rates of
1027 reimbursement.

1028 Notwithstanding any provision of this article, no new groups
1029 or categories of recipients and new types of care and services may
1030 be added without enabling legislation from the Mississippi
1031 Legislature, except that the division may authorize those changes
1032 without enabling legislation when the addition of recipients or
1033 services is ordered by a court of proper authority. The executive
1034 director shall keep the Governor advised on a timely basis of the
1035 funds available for expenditure and the projected expenditures.
1036 If current or projected expenditures of the division can be
1037 reasonably anticipated to exceed the amounts appropriated for any



1038 fiscal year, the Governor, after consultation with the executive
1039 director, shall discontinue any or all of the payment of the types
1040 of care and services as provided in this section that are deemed
1041 to be optional services under Title XIX of the federal Social
1042 Security Act, as amended, for any period necessary to not exceed
1043 appropriated funds, and when necessary shall institute any other
1044 cost containment measures on any program or programs authorized
1045 under the article to the extent allowed under the federal law
1046 governing that program or programs, it being the intent of the
1047 Legislature that expenditures during any fiscal year shall not
1048 exceed the amounts appropriated for that fiscal year.

1049 Notwithstanding any other provision of this article, it shall
1050 be the duty of each nursing facility, intermediate care facility
1051 for the mentally retarded, psychiatric residential treatment
1052 facility, and nursing facility for the severely disabled that is
1053 participating in the Medicaid program to keep and maintain books,
1054 documents and other records as prescribed by the Division of
1055 Medicaid in substantiation of its cost reports for a period of
1056 three (3) years after the date of submission to the Division of
1057 Medicaid of an original cost report, or three (3) years after the
1058 date of submission to the Division of Medicaid of an amended cost
1059 report.

1060 This section shall stand repealed on July 1, 2004.

1061 **SECTION 4.** Section 43-13-107, Mississippi Code of 1972, is
1062 amended as follows:

1063 43-13-107. (1) The Division of Medicaid is created in the
1064 Office of the Governor and established to administer this article
1065 and perform such other duties as are prescribed by law.

1066 (2) (a) The Governor shall appoint a full-time executive
1067 director, with the advice and consent of the Senate, who shall be
1068 either (i) a physician with administrative experience in a medical
1069 care or health program, or (ii) a person holding a graduate degree
1070 in medical care administration, public health, hospital



1071 administration, or the equivalent, or (iii) a person holding a
1072 bachelor's degree in business administration or hospital
1073 administration, with at least ten (10) years' experience in
1074 management-level administration of Medicaid programs, and who
1075 shall serve at the will and pleasure of the Governor. The
1076 executive director shall be the official secretary and legal
1077 custodian of the records of the division; shall be the agent of
1078 the division for the purpose of receiving all service of process,
1079 summons and notices directed to the division; and shall perform
1080 such other duties as the Governor may prescribe from time to time.

1081 (b) The executive director, with the approval of the
1082 Governor and subject to the rules and regulations of the State
1083 Personnel Board, shall employ such professional, administrative,
1084 stenographic, secretarial, clerical and technical assistance as
1085 may be necessary to perform the duties required in administering
1086 this article and fix the compensation therefor, all in accordance
1087 with a state merit system meeting federal requirements when the
1088 salary of the executive director is not set by law, that salary
1089 shall be set by the State Personnel Board. No employees of the
1090 Division of Medicaid shall be considered to be staff members of
1091 the immediate Office of the Governor; however, the provisions of
1092 Section 25-9-107(c) (xv) shall apply to the executive director and
1093 other administrative heads of the division.

1094 (3) (a) There is established a Medical Care Advisory
1095 Committee, which shall be the committee that is required by
1096 federal regulation to advise the Division of Medicaid about health
1097 and medical care services.

1098 (b) The advisory committee shall consist of not less
1099 than eleven (11) members, as follows:

1100 (i) The Governor shall appoint five (5) members,
1101 one (1) from each congressional district as presently constituted;

1102 (ii) The Lieutenant Governor shall appoint three
1103 (3) members, one (1) from each Supreme Court district;



1104 (iii) The Speaker of the House of Representatives
1105 shall appoint three (3) members, one (1) from each Supreme Court
1106 district.

1107 All members appointed under this paragraph shall either be
1108 health care providers or consumers of health care services. One
1109 (1) member appointed by each of the appointing authorities shall
1110 be a board certified physician.

1111 (c) The respective chairmen of the House Public Health
1112 and Welfare Committee, the House Appropriations Committee, the
1113 Senate Public Health and Welfare Committee and the Senate
1114 Appropriations Committee, or their designees, one (1) member of
1115 the State Senate appointed by the Lieutenant Governor and one (1)
1116 member of the House of Representatives appointed by the Speaker of
1117 the House, shall serve as ex officio nonvoting members of the
1118 advisory committee.

1119 (d) In addition to the committee members required by
1120 paragraph (b), the advisory committee shall consist of such other
1121 members as are necessary to meet the requirements of the federal
1122 regulation applicable to the advisory committee, who shall be
1123 appointed as provided in the federal regulation.

1124 (e) The chairmanship of the advisory committee shall
1125 alternate for twelve-month periods between the chairmen of the
1126 House and Senate Public Health and Welfare Committees, with the
1127 Chairman of the House Public Health and Welfare Committee serving
1128 as the first chairman.

1129 (f) The members of the advisory committee specified in
1130 paragraph (b) shall serve for terms that are concurrent with the
1131 terms of members of the Legislature, and any member appointed
1132 under paragraph (b) may be reappointed to the advisory committee.
1133 The members of the advisory committee specified in paragraph (b)
1134 shall serve without compensation, but shall receive reimbursement
1135 to defray actual expenses incurred in the performance of committee
1136 business as authorized by law. Legislators shall receive per diem



1137 and expenses which may be paid from the contingent expense funds
1138 of their respective houses in the same amounts as provided for
1139 committee meetings when the Legislature is not in session.

1140 (g) The advisory committee shall meet not less than
1141 quarterly, and advisory committee members shall be furnished
1142 written notice of the meetings at least ten (10) days before the
1143 date of the meeting.

1144 (h) The executive director shall submit to the advisory
1145 committee all amendments, modifications and changes to the state
1146 plan for the operation of the Medicaid program, for review by the
1147 advisory committee before the amendments, modifications or changes
1148 may be implemented by the division.

1149 (i) The advisory committee, among its duties and
1150 responsibilities, shall:

1151 (i) Advise the division with respect to
1152 amendments, modifications and changes to the state plan for the
1153 operation of the Medicaid program;

1154 (ii) Advise the division with respect to issues
1155 concerning receipt and disbursement of funds and eligibility for
1156 Medicaid;

1157 (iii) Advise the division with respect to
1158 determining the quantity, quality and extent of medical care
1159 provided under this article;

1160 (iv) Communicate the views of the medical care
1161 professions to the division and communicate the views of the
1162 division to the medical care professions;

1163 (v) Gather information on reasons that medical
1164 care providers do not participate in the Medicaid program and
1165 changes that could be made in the program to encourage more
1166 providers to participate in the Medicaid program, and advise the
1167 division with respect to encouraging physicians and other medical
1168 care providers to participate in the Medicaid program;



1169 (vi) Provide a written report on or before
1170 November 30 of each year to the Governor, Lieutenant Governor and
1171 Speaker of the House of Representatives.

1172 (4) (a) There is established a Drug Use Review Board, which
1173 shall be the board that is required by federal law to:

1174 (i) Review and initiate retrospective drug use,
1175 review including ongoing periodic examination of claims data and
1176 other records in order to identify patterns of fraud, abuse, gross
1177 overuse, or inappropriate or medically unnecessary care, among
1178 physicians, pharmacists and individuals receiving Medicaid
1179 benefits or associated with specific drugs or groups of drugs.

1180 (ii) Review and initiate ongoing interventions for
1181 physicians and pharmacists, targeted toward therapy problems or
1182 individuals identified in the course of retrospective drug use
1183 reviews.

1184 (iii) On an ongoing basis, assess data on drug use
1185 against explicit predetermined standards using the compendia and
1186 literature set forth in federal law and regulations.

1187 (b) The board shall consist of not less than twelve
1188 (12) members appointed by the Governor or his designee.

1189 (c) The board shall meet at least quarterly, and board
1190 members shall be furnished written notice of the meetings at least
1191 ten (10) days before the date of the meeting.

1192 (d) The board meetings shall be open to the public,
1193 members of the press, legislators and consumers. Additionally,
1194 all documents provided to board members shall be available to
1195 members of the Legislature in the same manner, and shall be made
1196 available to others for a reasonable fee for copying. However,
1197 patient confidentiality and provider confidentiality shall be
1198 protected by blinding patient names and provider names with
1199 numerical or other anonymous identifiers. The board meetings
1200 shall be subject to the Open Meetings Act (Section 25-41-1 et



1201 seq.). Board meetings conducted in violation of this section
1202 shall be deemed unlawful.

1203 (5) (a) There is established a Pharmacy and Therapeutics
1204 Committee, which shall be appointed by the Governor or his
1205 designee.

1206 (b) The committee shall meet at least quarterly, and
1207 committee members shall be furnished written notice of the
1208 meetings at least ten (10) days before the date of the meeting.

1209 (c) The committee meetings shall be open to the public,
1210 members of the press, legislators and consumers. Additionally,
1211 all documents provided to committee members shall be available to
1212 members of the Legislature in the same manner, and shall be made
1213 available to others for a reasonable fee for copying. However,
1214 patient confidentiality and provider confidentiality shall be
1215 protected by blinding patient names and provider names with
1216 numerical or other anonymous identifiers. The committee meetings
1217 shall be subject to the Open Meetings Act (Section 25-41-1 et
1218 seq.). Committee meetings conducted in violation of this section
1219 shall be deemed unlawful.

1220 (d) After a thirty-day public notice, the executive
1221 director or his or her designee shall present the division's
1222 recommendation regarding prior approval for a therapeutic class of
1223 drugs to the committee. However, in circumstances where the
1224 division deems it necessary for the health and safety of Medicaid
1225 beneficiaries, the division may present to the committee its
1226 recommendations regarding a particular drug without a thirty-day
1227 public notice. In making such presentation, the division shall
1228 state to the committee the circumstances which precipitate the
1229 need for the committee to review the status of a particular drug
1230 without a thirty-day public notice. The committee may determine
1231 whether or not to review the particular drug under the
1232 circumstances stated by the division without a thirty-day public
1233 notice. If the committee determines to review the status of the



1234 particular drug, it shall make its recommendations to the
1235 division, after which the division shall file such recommendations
1236 for a thirty-day public comment under the provisions of Section
1237 25-43-7(1), Mississippi Code of 1972.

1238 (e) Upon reviewing the information and recommendations,
1239 the committee shall forward a written recommendation approved by a
1240 majority of the committee to the executive director or his or her
1241 designee. The decisions of the committee regarding any
1242 limitations to be imposed on any drug or its use for a specified
1243 indication shall be based on sound clinical evidence found in
1244 labeling, drug compendia, and peer reviewed clinical literature
1245 pertaining to use of the drug in the relevant population.

1246 (f) Upon reviewing and considering all recommendations
1247 including recommendation of the committee, comments, and data, the
1248 executive director shall make a final determination whether to
1249 require prior approval of a therapeutic class of drugs, or modify
1250 existing prior approval requirements for a therapeutic class of
1251 drugs.

1252 (g) At least thirty (30) days before the executive
1253 director implements new or amended prior authorization decisions,
1254 written notice of the executive director's decision shall be
1255 provided to all prescribing Medicaid providers, all Medicaid
1256 enrolled pharmacies, and any other party who has requested the
1257 notification. However, notice given under Section 25-43-7(1) will
1258 substitute for and meet the requirement for notice under this
1259 subsection.

1260 (6) This section shall stand repealed on July 1, 2004.

1261 **SECTION 5.** Section 43-13-122, Mississippi Code of 1972, is
1262 amended as follows:

1263 43-13-122. (1) The division is authorize to apply to the
1264 Center for Medicare and Medicaid Services of the United States
1265 Department of Health and Human Services for waivers and research
1266 and demonstration grants * * *.



1267 (2) The division is further authorized to accept and expend
1268 any grants, donations or contributions from any public or private
1269 organization together with any additional federal matching funds
1270 that may accrue and including, but not limited to, one hundred
1271 percent (100%) federal grant funds or funds from any governmental
1272 entity or instrumentality thereof in furthering the purposes and
1273 objectives of the Mississippi Medicaid program, provided that such
1274 receipts and expenditures are reported and otherwise handled in
1275 accordance with the General Fund Stabilization Act. The
1276 Department of Finance and Administration is authorized to transfer
1277 monies to the division from special funds in the State Treasury in
1278 amounts not exceeding the amounts authorized in the appropriation
1279 to the division.

1280 **SECTION 6.** Section 43-13-145, Mississippi Code of 1972, is
1281 amended as follows:

1282 43-13-145. (1) (a) Upon each nursing facility and each
1283 intermediate care facility for the mentally retarded licensed by
1284 the State of Mississippi, there is levied an assessment in the
1285 amount of Four Dollars (\$4.00) per day for each licensed and/or
1286 certified bed of the facility. The division may apply for a
1287 waiver from the United States Secretary of Health and Human
1288 Services to exempt nonprofit, public, charitable or religious
1289 facilities from the assessment levied under this subsection, and
1290 if a waiver is granted, those facilities shall be exempt from any
1291 assessment levied under this subsection after the date that the
1292 division receives notice that the waiver has been granted.

1293 (b) A nursing facility or intermediate care facility
1294 for the mentally retarded is exempt from the assessment levied
1295 under this subsection if the facility is operated under the
1296 direction and control of:

1297 (i) The United States Veterans Administration or
1298 other agency or department of the United States government;

1299 (ii) The State Veterans Affairs Board;



1300 (iii) The University of Mississippi Medical
1301 Center; or

1302 (iv) A state agency or a state facility that
1303 either provides its own state match through intergovernmental
1304 transfer or certification of funds to the division.

1305 (2) (a) Upon each psychiatric residential treatment
1306 facility licensed by the State of Mississippi, there is levied an
1307 assessment in the amount of Three Dollars (\$3.00) per day for each
1308 licensed and/or certified bed of the facility.

1309 (b) A psychiatric residential treatment facility is
1310 exempt from the assessment levied under this subsection if the
1311 facility is operated under the direction and control of:

1312 (i) The United States Veterans Administration or
1313 other agency or department of the United States government;

1314 (ii) The University of Mississippi Medical Center;

1315 (iii) A state agency or a state facility that
1316 either provides its own state match through intergovernmental
1317 transfer or certification of funds to the division.

1318 (3) (a) Upon each hospital licensed by the State of
1319 Mississippi, there is levied an assessment in the amount of One
1320 Dollar and Fifty Cents (\$1.50) per day for each licensed inpatient
1321 acute care bed of the hospital.

1322 (b) A hospital is exempt from the assessment levied
1323 under this subsection if the hospital is operated under the
1324 direction and control of:

1325 (i) The United States Veterans Administration or
1326 other agency or department of the United States government;

1327 (ii) The University of Mississippi Medical Center;

1328 or

1329 (iii) A state agency or a state facility that
1330 either provides its own state match through intergovernmental
1331 transfer or certification of funds to the division.



1332 (4) Each health care facility that is subject to the
1333 provisions of this section shall keep and preserve such suitable
1334 books and records as may be necessary to determine the amount of
1335 assessment for which it is liable under this section. The books
1336 and records shall be kept and preserved for a period of not less
1337 than five (5) years, and those books and records shall be open for
1338 examination during business hours by the division, the State Tax
1339 Commission, the Office of the Attorney General and the State
1340 Department of Health.

1341 (5) The assessment levied under this section shall be
1342 collected by the division each month beginning on April 12, 2002.

1343 (6) All assessments collected under this section shall be
1344 deposited in the Medical Care Fund created by Section 43-13-143.

1345 (7) The assessment levied under this section shall be in
1346 addition to any other assessments, taxes or fees levied by law,
1347 and the assessment shall constitute a debt due the State of
1348 Mississippi from the time the assessment is due until it is paid.

1349 (8) (a) If a health care facility that is liable for
1350 payment of the assessment levied under this section does not pay
1351 the assessment when it is due, the division shall give written
1352 notice to the health care facility by certified or registered mail
1353 demanding payment of the assessment within ten (10) days from the
1354 date of delivery of the notice. If the health care facility
1355 fails or refuses to pay the assessment after receiving the notice
1356 and demand from the division, the division shall withhold from any
1357 Medicaid reimbursement payments that are due to the health care
1358 facility the amount of the unpaid assessment and a penalty of ten
1359 percent (10%) of the amount of the assessment, plus the legal rate
1360 of interest until the assessment is paid in full. If the health
1361 care facility does not participate in the Medicaid program, the
1362 division shall turn over to the Office of the Attorney General the
1363 collection of the unpaid assessment by civil action. In any such
1364 civil action, the Office of the Attorney General shall collect the



1365 amount of the unpaid assessment and a penalty of ten percent (10%)
1366 of the amount of the assessment, plus the legal rate of interest
1367 until the assessment is paid in full.

1368 (b) As an additional or alternative method for
1369 collecting unpaid assessments under this section, if a health care
1370 facility fails or refuses to pay the assessment after receiving
1371 notice and demand from the division, the division may file a
1372 notice of a tax lien with the circuit clerk of the county in which
1373 the health care facility is located, for the amount of the unpaid
1374 assessment and a penalty of ten percent (10%) of the amount of the
1375 assessment, plus the legal rate of interest until the assessment
1376 is paid in full. Immediately upon receipt of notice of the tax
1377 lien for the assessment, the circuit clerk shall enter the notice
1378 of the tax lien as a judgment upon the judgment roll and show in
1379 the appropriate columns the name of the health care facility as
1380 judgment debtor, the name of the division as judgment creditor,
1381 the amount of the unpaid assessment, and the date and time or
1382 enrollment. The judgment shall be valid as against mortgagees,
1383 pledgees, entrusters, purchasers, judgment creditors and other
1384 persons from the time of filing with the clerk. The amount of the
1385 judgment shall be a debt due the State of Mississippi and remain a
1386 lien upon the tangible property of the health care facility until
1387 the judgment is satisfied. The judgment shall be the equivalent
1388 of any enrolled judgment of a court of record and shall serve as
1389 authority for the issuance of writs of execution, writs of
1390 attachment or other remedial writs.

1391 **SECTION 7.** Section 41-7-191, Mississippi Code of 1972, is
1392 amended as follows:

1393 41-7-191. (1) No person shall engage in any of the
1394 following activities without obtaining the required certificate of
1395 need:

1396 (a) The construction, development or other
1397 establishment of a new health care facility;



1398 (b) The relocation of a health care facility or portion
1399 thereof, or major medical equipment, unless such relocation of a
1400 health care facility or portion thereof, or major medical
1401 equipment, which does not involve a capital expenditure by or on
1402 behalf of a health care facility, is within five thousand two
1403 hundred eighty (5,280) feet from the main entrance of the health
1404 care facility;

1405 (c) Any change in the existing bed complement of any
1406 health care facility through the addition or conversion of any
1407 beds or the alteration, modernizing or refurbishing of any unit or
1408 department in which the beds may be located;

1409 (d) Offering of the following health services if those
1410 services have not been provided on a regular basis by the proposed
1411 provider of such services within the period of twelve (12) months
1412 prior to the time such services would be offered:

- 1413 (i) Open heart surgery services;
- 1414 (ii) Cardiac catheterization services;
- 1415 (iii) Comprehensive inpatient rehabilitation
1416 services;
- 1417 (iv) Licensed psychiatric services;
- 1418 (v) Licensed chemical dependency services;
- 1419 (vi) Radiation therapy services;
- 1420 (vii) Diagnostic imaging services of an invasive
1421 nature, i.e. invasive digital angiography;
- 1422 (viii) Nursing home care as defined in
1423 subparagraphs (iv), (vi) and (viii) of Section 41-7-173(h);
- 1424 (ix) Home health services;
- 1425 (x) Swing-bed services;
- 1426 (xi) Ambulatory surgical services;
- 1427 (xii) Magnetic resonance imaging services;
- 1428 (xiii) Extracorporeal shock wave lithotripsy
1429 services;
- 1430 (xiv) Long-term care hospital services;



1431 (xv) Positron Emission Tomography (PET) services;

1432 (e) The relocation of one or more health services from
1433 one physical facility or site to another physical facility or
1434 site, unless such relocation, which does not involve a capital
1435 expenditure by or on behalf of a health care facility, (i) is to a
1436 physical facility or site within one thousand three hundred twenty
1437 (1,320) feet from the main entrance of the health care facility
1438 where the health care service is located, or (ii) is the result of
1439 an order of a court of appropriate jurisdiction or a result of
1440 pending litigation in such court, or by order of the State
1441 Department of Health, or by order of any other agency or legal
1442 entity of the state, the federal government, or any political
1443 subdivision of either, whose order is also approved by the State
1444 Department of Health;

1445 (f) The acquisition or otherwise control of any major
1446 medical equipment for the provision of medical services; provided,
1447 however, (i) the acquisition of any major medical equipment used
1448 only for research purposes, and (ii) the acquisition of major
1449 medical equipment to replace medical equipment for which a
1450 facility is already providing medical services and for which the
1451 State Department of Health has been notified before the date of
1452 such acquisition shall be exempt from this paragraph; an
1453 acquisition for less than fair market value must be reviewed, if
1454 the acquisition at fair market value would be subject to review;

1455 (g) Changes of ownership of existing health care
1456 facilities in which a notice of intent is not filed with the State
1457 Department of Health at least thirty (30) days prior to the date
1458 such change of ownership occurs, or a change in services or bed
1459 capacity as prescribed in paragraph (c) or (d) of this subsection
1460 as a result of the change of ownership; an acquisition for less
1461 than fair market value must be reviewed, if the acquisition at
1462 fair market value would be subject to review;



1463 (h) The change of ownership of any health care facility
1464 defined in subparagraphs (iv), (vi) and (viii) of Section
1465 41-7-173(h), in which a notice of intent as described in paragraph
1466 (g) has not been filed and if the Executive Director, Division of
1467 Medicaid, Office of the Governor, has not certified in writing
1468 that there will be no increase in allowable costs to Medicaid from
1469 revaluation of the assets or from increased interest and
1470 depreciation as a result of the proposed change of ownership;

1471 (i) Any activity described in paragraphs (a) through
1472 (h) if undertaken by any person if that same activity would
1473 require certificate of need approval if undertaken by a health
1474 care facility;

1475 (j) Any capital expenditure or deferred capital
1476 expenditure by or on behalf of a health care facility not covered
1477 by paragraphs (a) through (h);

1478 (k) The contracting of a health care facility as
1479 defined in subparagraphs (i) through (viii) of Section 41-7-173(h)
1480 to establish a home office, subunit, or branch office in the space
1481 operated as a health care facility through a formal arrangement
1482 with an existing health care facility as defined in subparagraph
1483 (ix) of Section 41-7-173(h).

1484 (2) From and after the effective date of Senate Bill No.
1485 2346 (2003 Regular Session), the State Department of Health shall
1486 not issue a certificate of need to any person for the new
1487 construction of, addition to, expansion of or conversion to any
1488 skilled or intermediate care nursing facility beds or services.
1489 Provided, that this prohibition shall not apply to any certificate
1490 of need approved by the department but not issued due to a
1491 judicial appeal of the order approving the issuance thereof.
1492 Prior to the effective date of Senate Bill No. 2346 (2003 Regular
1493 Session) the State Department of Health shall not grant approval
1494 for or issue a certificate of need to any person proposing the new
1495 construction of, addition to, or expansion of any health care



1496 facility defined in subparagraphs (iv) (skilled nursing facility)
1497 and (vi) (intermediate care facility) of Section 41-7-173(h) or
1498 the conversion of vacant hospital beds to provide skilled or
1499 intermediate nursing home care, except as hereinafter authorized:

1500 (a) The department may issue a certificate of need to
1501 any person proposing the new construction of any health care
1502 facility defined in subparagraphs (iv) and (vi) of Section
1503 41-7-173(h) as part of a life care retirement facility, in any
1504 county bordering on the Gulf of Mexico in which is located a
1505 National Aeronautics and Space Administration facility, not to
1506 exceed forty (40) beds. From and after July 1, 1999, there shall
1507 be no prohibition or restrictions on participation in the Medicaid
1508 program (Section 43-13-101 et seq.) for the beds in the health
1509 care facility that were authorized under this paragraph (a).

1510 (b) The department may issue certificates of need in
1511 Harrison County to provide skilled nursing home care for
1512 Alzheimer's disease patients and other patients, not to exceed one
1513 hundred fifty (150) beds. From and after July 1, 1999, there
1514 shall be no prohibition or restrictions on participation in the
1515 Medicaid program (Section 43-13-101 et seq.) for the beds in the
1516 nursing facilities that were authorized under this paragraph (b).

1517 (c) The department may issue a certificate of need for
1518 the addition to or expansion of any skilled nursing facility that
1519 is part of an existing continuing care retirement community
1520 located in Madison County, provided that the recipient of the
1521 certificate of need agrees in writing that the skilled nursing
1522 facility will not at any time participate in the Medicaid program
1523 (Section 43-13-101 et seq.) or admit or keep any patients in the
1524 skilled nursing facility who are participating in the Medicaid
1525 program. This written agreement by the recipient of the
1526 certificate of need shall be fully binding on any subsequent owner
1527 of the skilled nursing facility, if the ownership of the facility
1528 is transferred at any time after the issuance of the certificate



1529 of need. Agreement that the skilled nursing facility will not
1530 participate in the Medicaid program shall be a condition of the
1531 issuance of a certificate of need to any person under this
1532 paragraph (c), and if such skilled nursing facility at any time
1533 after the issuance of the certificate of need, regardless of the
1534 ownership of the facility, participates in the Medicaid program or
1535 admits or keeps any patients in the facility who are participating
1536 in the Medicaid program, the State Department of Health shall
1537 revoke the certificate of need, if it is still outstanding, and
1538 shall deny or revoke the license of the skilled nursing facility,
1539 at the time that the department determines, after a hearing
1540 complying with due process, that the facility has failed to comply
1541 with any of the conditions upon which the certificate of need was
1542 issued, as provided in this paragraph and in the written agreement
1543 by the recipient of the certificate of need. The total number of
1544 beds that may be authorized under the authority of this paragraph
1545 (c) shall not exceed sixty (60) beds.

1546 (d) The State Department of Health may issue a
1547 certificate of need to any hospital located in DeSoto County for
1548 the new construction of a skilled nursing facility, not to exceed
1549 one hundred twenty (120) beds, in DeSoto County. From and after
1550 July 1, 1999, there shall be no prohibition or restrictions on
1551 participation in the Medicaid program (Section 43-13-101 et seq.)
1552 for the beds in the nursing facility that were authorized under
1553 this paragraph (d).

1554 (e) The State Department of Health may issue a
1555 certificate of need for the construction of a nursing facility or
1556 the conversion of beds to nursing facility beds at a personal care
1557 facility for the elderly in Lowndes County that is owned and
1558 operated by a Mississippi nonprofit corporation, not to exceed
1559 sixty (60) beds. From and after July 1, 1999, there shall be no
1560 prohibition or restrictions on participation in the Medicaid



1561 program (Section 43-13-101 et seq.) for the beds in the nursing
1562 facility that were authorized under this paragraph (e).

1563 (f) The State Department of Health may issue a
1564 certificate of need for conversion of a county hospital facility
1565 in Itawamba County to a nursing facility, not to exceed sixty (60)
1566 beds, including any necessary construction, renovation or
1567 expansion. From and after July 1, 1999, there shall be no
1568 prohibition or restrictions on participation in the Medicaid
1569 program (Section 43-13-101 et seq.) for the beds in the nursing
1570 facility that were authorized under this paragraph (f).

1571 (g) The State Department of Health may issue a
1572 certificate of need for the construction or expansion of nursing
1573 facility beds or the conversion of other beds to nursing facility
1574 beds in either Hinds, Madison or Rankin County, not to exceed
1575 sixty (60) beds. From and after July 1, 1999, there shall be no
1576 prohibition or restrictions on participation in the Medicaid
1577 program (Section 43-13-101 et seq.) for the beds in the nursing
1578 facility that were authorized under this paragraph (g).

1579 (h) The State Department of Health may issue a
1580 certificate of need for the construction or expansion of nursing
1581 facility beds or the conversion of other beds to nursing facility
1582 beds in either Hancock, Harrison or Jackson County, not to exceed
1583 sixty (60) beds. From and after July 1, 1999, there shall be no
1584 prohibition or restrictions on participation in the Medicaid
1585 program (Section 43-13-101 et seq.) for the beds in the facility
1586 that were authorized under this paragraph (h).

1587 (i) The department may issue a certificate of need for
1588 the new construction of a skilled nursing facility in Leake
1589 County, provided that the recipient of the certificate of need
1590 agrees in writing that the skilled nursing facility will not at
1591 any time participate in the Medicaid program (Section 43-13-101 et
1592 seq.) or admit or keep any patients in the skilled nursing
1593 facility who are participating in the Medicaid program. This



1594 written agreement by the recipient of the certificate of need
1595 shall be fully binding on any subsequent owner of the skilled
1596 nursing facility, if the ownership of the facility is transferred
1597 at any time after the issuance of the certificate of need.
1598 Agreement that the skilled nursing facility will not participate
1599 in the Medicaid program shall be a condition of the issuance of a
1600 certificate of need to any person under this paragraph (i), and if
1601 such skilled nursing facility at any time after the issuance of
1602 the certificate of need, regardless of the ownership of the
1603 facility, participates in the Medicaid program or admits or keeps
1604 any patients in the facility who are participating in the Medicaid
1605 program, the State Department of Health shall revoke the
1606 certificate of need, if it is still outstanding, and shall deny or
1607 revoke the license of the skilled nursing facility, at the time
1608 that the department determines, after a hearing complying with due
1609 process, that the facility has failed to comply with any of the
1610 conditions upon which the certificate of need was issued, as
1611 provided in this paragraph and in the written agreement by the
1612 recipient of the certificate of need. The provision of Section
1613 43-7-193(1) regarding substantial compliance of the projection of
1614 need as reported in the current State Health Plan is waived for
1615 the purposes of this paragraph. The total number of nursing
1616 facility beds that may be authorized by any certificate of need
1617 issued under this paragraph (i) shall not exceed sixty (60) beds.
1618 If the skilled nursing facility authorized by the certificate of
1619 need issued under this paragraph is not constructed and fully
1620 operational within eighteen (18) months after July 1, 1994, the
1621 State Department of Health, after a hearing complying with due
1622 process, shall revoke the certificate of need, if it is still
1623 outstanding, and shall not issue a license for the skilled nursing
1624 facility at any time after the expiration of the eighteen-month
1625 period.



1626 (j) The department may issue certificates of need to
1627 allow any existing freestanding long-term care facility in
1628 Tishomingo County and Hancock County that on July 1, 1995, is
1629 licensed with fewer than sixty (60) beds. For the purposes of
1630 this paragraph (j), the provision of Section 41-7-193(1) requiring
1631 substantial compliance with the projection of need as reported in
1632 the current State Health Plan is waived. From and after July 1,
1633 1999, there shall be no prohibition or restrictions on
1634 participation in the Medicaid program (Section 43-13-101 et seq.)
1635 for the beds in the long-term care facilities that were authorized
1636 under this paragraph (j).

1637 (k) The department may issue a certificate of need for
1638 the construction of a nursing facility at a continuing care
1639 retirement community in Lowndes County. The total number of beds
1640 that may be authorized under the authority of this paragraph (k)
1641 shall not exceed sixty (60) beds. From and after July 1, 2001,
1642 the prohibition on the facility participating in the Medicaid
1643 program (Section 43-13-101 et seq.) that was a condition of
1644 issuance of the certificate of need under this paragraph (k) shall
1645 be revised as follows: The nursing facility may participate in
1646 the Medicaid program from and after July 1, 2001, if the owner of
1647 the facility on July 1, 2001, agrees in writing that no more than
1648 thirty (30) of the beds at the facility will be certified for
1649 participation in the Medicaid program, and that no claim will be
1650 submitted for Medicaid reimbursement for more than thirty (30)
1651 patients in the facility in any month or for any patient in the
1652 facility who is in a bed that is not Medicaid-certified. This
1653 written agreement by the owner of the facility shall be a
1654 condition of licensure of the facility, and the agreement shall be
1655 fully binding on any subsequent owner of the facility if the
1656 ownership of the facility is transferred at any time after July 1,
1657 2001. After this written agreement is executed, the Division of
1658 Medicaid and the State Department of Health shall not certify more



1659 than thirty (30) of the beds in the facility for participation in
1660 the Medicaid program. If the facility violates the terms of the
1661 written agreement by admitting or keeping in the facility on a
1662 regular or continuing basis more than thirty (30) patients who are
1663 participating in the Medicaid program, the State Department of
1664 Health shall revoke the license of the facility, at the time that
1665 the department determines, after a hearing complying with due
1666 process, that the facility has violated the written agreement.

1667 (l) Provided that funds are specifically appropriated
1668 therefor by the Legislature, the department may issue a
1669 certificate of need to a rehabilitation hospital in Hinds County
1670 for the construction of a sixty-bed long-term care nursing
1671 facility dedicated to the care and treatment of persons with
1672 severe disabilities including persons with spinal cord and
1673 closed-head injuries and ventilator-dependent patients. The
1674 provision of Section 41-7-193(1) regarding substantial compliance
1675 with projection of need as reported in the current State Health
1676 Plan is hereby waived for the purpose of this paragraph.

1677 (m) The State Department of Health may issue a
1678 certificate of need to a county-owned hospital in the Second
1679 Judicial District of Panola County for the conversion of not more
1680 than seventy-two (72) hospital beds to nursing facility beds,
1681 provided that the recipient of the certificate of need agrees in
1682 writing that none of the beds at the nursing facility will be
1683 certified for participation in the Medicaid program (Section
1684 43-13-101 et seq.), and that no claim will be submitted for
1685 Medicaid reimbursement in the nursing facility in any day or for
1686 any patient in the nursing facility. This written agreement by
1687 the recipient of the certificate of need shall be a condition of
1688 the issuance of the certificate of need under this paragraph, and
1689 the agreement shall be fully binding on any subsequent owner of
1690 the nursing facility if the ownership of the nursing facility is
1691 transferred at any time after the issuance of the certificate of



1692 need. After this written agreement is executed, the Division of
1693 Medicaid and the State Department of Health shall not certify any
1694 of the beds in the nursing facility for participation in the
1695 Medicaid program. If the nursing facility violates the terms of
1696 the written agreement by admitting or keeping in the nursing
1697 facility on a regular or continuing basis any patients who are
1698 participating in the Medicaid program, the State Department of
1699 Health shall revoke the license of the nursing facility, at the
1700 time that the department determines, after a hearing complying
1701 with due process, that the nursing facility has violated the
1702 condition upon which the certificate of need was issued, as
1703 provided in this paragraph and in the written agreement. If the
1704 certificate of need authorized under this paragraph is not issued
1705 within twelve (12) months after July 1, 2001, the department shall
1706 deny the application for the certificate of need and shall not
1707 issue the certificate of need at any time after the twelve-month
1708 period, unless the issuance is contested. If the certificate of
1709 need is issued and substantial construction of the nursing
1710 facility beds has not commenced within eighteen (18) months after
1711 July 1, 2001, the State Department of Health, after a hearing
1712 complying with due process, shall revoke the certificate of need
1713 if it is still outstanding, and the department shall not issue a
1714 license for the nursing facility at any time after the
1715 eighteen-month period. Provided, however, that if the issuance of
1716 the certificate of need is contested, the department shall require
1717 substantial construction of the nursing facility beds within six
1718 (6) months after final adjudication on the issuance of the
1719 certificate of need.

1720 (n) The department may issue a certificate of need for
1721 the new construction, addition or conversion of skilled nursing
1722 facility beds in Madison County, provided that the recipient of
1723 the certificate of need agrees in writing that the skilled nursing
1724 facility will not at any time participate in the Medicaid program



1725 (Section 43-13-101 et seq.) or admit or keep any patients in the
1726 skilled nursing facility who are participating in the Medicaid
1727 program. This written agreement by the recipient of the
1728 certificate of need shall be fully binding on any subsequent owner
1729 of the skilled nursing facility, if the ownership of the facility
1730 is transferred at any time after the issuance of the certificate
1731 of need. Agreement that the skilled nursing facility will not
1732 participate in the Medicaid program shall be a condition of the
1733 issuance of a certificate of need to any person under this
1734 paragraph (n), and if such skilled nursing facility at any time
1735 after the issuance of the certificate of need, regardless of the
1736 ownership of the facility, participates in the Medicaid program or
1737 admits or keeps any patients in the facility who are participating
1738 in the Medicaid program, the State Department of Health shall
1739 revoke the certificate of need, if it is still outstanding, and
1740 shall deny or revoke the license of the skilled nursing facility,
1741 at the time that the department determines, after a hearing
1742 complying with due process, that the facility has failed to comply
1743 with any of the conditions upon which the certificate of need was
1744 issued, as provided in this paragraph and in the written agreement
1745 by the recipient of the certificate of need. The total number of
1746 nursing facility beds that may be authorized by any certificate of
1747 need issued under this paragraph (n) shall not exceed sixty (60)
1748 beds. If the certificate of need authorized under this paragraph
1749 is not issued within twelve (12) months after July 1, 1998, the
1750 department shall deny the application for the certificate of need
1751 and shall not issue the certificate of need at any time after the
1752 twelve-month period, unless the issuance is contested. If the
1753 certificate of need is issued and substantial construction of the
1754 nursing facility beds has not commenced within eighteen (18)
1755 months after the effective date of July 1, 1998, the State
1756 Department of Health, after a hearing complying with due process,
1757 shall revoke the certificate of need if it is still outstanding,



1758 and the department shall not issue a license for the nursing
1759 facility at any time after the eighteen-month period. Provided,
1760 however, that if the issuance of the certificate of need is
1761 contested, the department shall require substantial construction
1762 of the nursing facility beds within six (6) months after final
1763 adjudication on the issuance of the certificate of need.

1764 (o) The department may issue a certificate of need for
1765 the new construction, addition or conversion of skilled nursing
1766 facility beds in Leake County, provided that the recipient of the
1767 certificate of need agrees in writing that the skilled nursing
1768 facility will not at any time participate in the Medicaid program
1769 (Section 43-13-101 et seq.) or admit or keep any patients in the
1770 skilled nursing facility who are participating in the Medicaid
1771 program. This written agreement by the recipient of the
1772 certificate of need shall be fully binding on any subsequent owner
1773 of the skilled nursing facility, if the ownership of the facility
1774 is transferred at any time after the issuance of the certificate
1775 of need. Agreement that the skilled nursing facility will not
1776 participate in the Medicaid program shall be a condition of the
1777 issuance of a certificate of need to any person under this
1778 paragraph (o), and if such skilled nursing facility at any time
1779 after the issuance of the certificate of need, regardless of the
1780 ownership of the facility, participates in the Medicaid program or
1781 admits or keeps any patients in the facility who are participating
1782 in the Medicaid program, the State Department of Health shall
1783 revoke the certificate of need, if it is still outstanding, and
1784 shall deny or revoke the license of the skilled nursing facility,
1785 at the time that the department determines, after a hearing
1786 complying with due process, that the facility has failed to comply
1787 with any of the conditions upon which the certificate of need was
1788 issued, as provided in this paragraph and in the written agreement
1789 by the recipient of the certificate of need. The total number of
1790 nursing facility beds that may be authorized by any certificate of



1791 need issued under this paragraph (o) shall not exceed sixty (60)
1792 beds. If the certificate of need authorized under this paragraph
1793 is not issued within twelve (12) months after July 1, 2001, the
1794 department shall deny the application for the certificate of need
1795 and shall not issue the certificate of need at any time after the
1796 twelve-month period, unless the issuance is contested. If the
1797 certificate of need is issued and substantial construction of the
1798 nursing facility beds has not commenced within eighteen (18)
1799 months after the effective date of July 1, 2001, the State
1800 Department of Health, after a hearing complying with due process,
1801 shall revoke the certificate of need if it is still outstanding,
1802 and the department shall not issue a license for the nursing
1803 facility at any time after the eighteen-month period. Provided,
1804 however, that if the issuance of the certificate of need is
1805 contested, the department shall require substantial construction
1806 of the nursing facility beds within six (6) months after final
1807 adjudication on the issuance of the certificate of need.

1808 (p) The department may issue a certificate of need for
1809 the construction of a municipally-owned nursing facility within
1810 the Town of Belmont in Tishomingo County, not to exceed sixty (60)
1811 beds, provided that the recipient of the certificate of need
1812 agrees in writing that the skilled nursing facility will not at
1813 any time participate in the Medicaid program (Section 43-13-101 et
1814 seq.) or admit or keep any patients in the skilled nursing
1815 facility who are participating in the Medicaid program. This
1816 written agreement by the recipient of the certificate of need
1817 shall be fully binding on any subsequent owner of the skilled
1818 nursing facility, if the ownership of the facility is transferred
1819 at any time after the issuance of the certificate of need.
1820 Agreement that the skilled nursing facility will not participate
1821 in the Medicaid program shall be a condition of the issuance of a
1822 certificate of need to any person under this paragraph (p), and if
1823 such skilled nursing facility at any time after the issuance of



1824 the certificate of need, regardless of the ownership of the
1825 facility, participates in the Medicaid program or admits or keeps
1826 any patients in the facility who are participating in the Medicaid
1827 program, the State Department of Health shall revoke the
1828 certificate of need, if it is still outstanding, and shall deny or
1829 revoke the license of the skilled nursing facility, at the time
1830 that the department determines, after a hearing complying with due
1831 process, that the facility has failed to comply with any of the
1832 conditions upon which the certificate of need was issued, as
1833 provided in this paragraph and in the written agreement by the
1834 recipient of the certificate of need. The provision of Section
1835 43-7-193(1) regarding substantial compliance of the projection of
1836 need as reported in the current State Health Plan is waived for
1837 the purposes of this paragraph. If the certificate of need
1838 authorized under this paragraph is not issued within twelve (12)
1839 months after July 1, 1998, the department shall deny the
1840 application for the certificate of need and shall not issue the
1841 certificate of need at any time after the twelve-month period,
1842 unless the issuance is contested. If the certificate of need is
1843 issued and substantial construction of the nursing facility beds
1844 has not commenced within eighteen (18) months after July 1, 1998,
1845 the State Department of Health, after a hearing complying with due
1846 process, shall revoke the certificate of need if it is still
1847 outstanding, and the department shall not issue a license for the
1848 nursing facility at any time after the eighteen-month period.
1849 Provided, however, that if the issuance of the certificate of need
1850 is contested, the department shall require substantial
1851 construction of the nursing facility beds within six (6) months
1852 after final adjudication on the issuance of the certificate of
1853 need.

1854 (q) (i) Beginning on July 1, 1999, the State
1855 Department of Health shall issue certificates of need during each
1856 of the next four (4) fiscal years for the construction or



1857 expansion of nursing facility beds or the conversion of other beds
1858 to nursing facility beds in each county in the state having a need
1859 for fifty (50) or more additional nursing facility beds, as shown
1860 in the fiscal year 1999 State Health Plan, in the manner provided
1861 in this paragraph (q). The total number of nursing facility beds
1862 that may be authorized by any certificate of need authorized under
1863 this paragraph (q) shall not exceed sixty (60) beds.

1864 (ii) Subject to the provisions of subparagraph
1865 (v), during each of the next four (4) fiscal years, the department
1866 shall issue six (6) certificates of need for new nursing facility
1867 beds, as follows: During fiscal years 2000, 2001 and 2002, one
1868 (1) certificate of need shall be issued for new nursing facility
1869 beds in the county in each of the four (4) Long-Term Care Planning
1870 Districts designated in the fiscal year 1999 State Health Plan
1871 that has the highest need in the district for those beds; and two
1872 (2) certificates of need shall be issued for new nursing facility
1873 beds in the two (2) counties from the state at large that have the
1874 highest need in the state for those beds, when considering the
1875 need on a statewide basis and without regard to the Long-Term Care
1876 Planning Districts in which the counties are located. During
1877 fiscal year 2003, one (1) certificate of need shall be issued for
1878 new nursing facility beds in any county having a need for fifty
1879 (50) or more additional nursing facility beds, as shown in the
1880 fiscal year 1999 State Health Plan, that has not received a
1881 certificate of need under this paragraph (q) during the three (3)
1882 previous fiscal years. During fiscal year 2000, in addition to
1883 the six (6) certificates of need authorized in this subparagraph,
1884 the department also shall issue a certificate of need for new
1885 nursing facility beds in Amite County and a certificate of need
1886 for new nursing facility beds in Carroll County.

1887 (iii) Subject to the provisions of subparagraph
1888 (v), the certificate of need issued under subparagraph (ii) for
1889 nursing facility beds in each Long-Term Care Planning District



1890 during each fiscal year shall first be available for nursing
1891 facility beds in the county in the district having the highest
1892 need for those beds, as shown in the fiscal year 1999 State Health
1893 Plan. If there are no applications for a certificate of need for
1894 nursing facility beds in the county having the highest need for
1895 those beds by the date specified by the department, then the
1896 certificate of need shall be available for nursing facility beds
1897 in other counties in the district in descending order of the need
1898 for those beds, from the county with the second highest need to
1899 the county with the lowest need, until an application is received
1900 for nursing facility beds in an eligible county in the district.

1901 (iv) Subject to the provisions of subparagraph
1902 (v), the certificate of need issued under subparagraph (ii) for
1903 nursing facility beds in the two (2) counties from the state at
1904 large during each fiscal year shall first be available for nursing
1905 facility beds in the two (2) counties that have the highest need
1906 in the state for those beds, as shown in the fiscal year 1999
1907 State Health Plan, when considering the need on a statewide basis
1908 and without regard to the Long-Term Care Planning Districts in
1909 which the counties are located. If there are no applications for
1910 a certificate of need for nursing facility beds in either of the
1911 two (2) counties having the highest need for those beds on a
1912 statewide basis by the date specified by the department, then the
1913 certificate of need shall be available for nursing facility beds
1914 in other counties from the state at large in descending order of
1915 the need for those beds on a statewide basis, from the county with
1916 the second highest need to the county with the lowest need, until
1917 an application is received for nursing facility beds in an
1918 eligible county from the state at large.

1919 (v) If a certificate of need is authorized to be
1920 issued under this paragraph (q) for nursing facility beds in a
1921 county on the basis of the need in the Long-Term Care Planning
1922 District during any fiscal year of the four-year period, a



1923 certificate of need shall not also be available under this
1924 paragraph (q) for additional nursing facility beds in that county
1925 on the basis of the need in the state at large, and that county
1926 shall be excluded in determining which counties have the highest
1927 need for nursing facility beds in the state at large for that
1928 fiscal year. After a certificate of need has been issued under
1929 this paragraph (q) for nursing facility beds in a county during
1930 any fiscal year of the four-year period, a certificate of need
1931 shall not be available again under this paragraph (q) for
1932 additional nursing facility beds in that county during the
1933 four-year period, and that county shall be excluded in determining
1934 which counties have the highest need for nursing facility beds in
1935 succeeding fiscal years.

1936 (vi) If more than one (1) application is made for
1937 a certificate of need for nursing home facility beds available
1938 under this paragraph (q), in Yalobusha, Newton or Tallahatchie
1939 County, and one (1) of the applicants is a county-owned hospital
1940 located in the county where the nursing facility beds are
1941 available, the department shall give priority to the county-owned
1942 hospital in granting the certificate of need if the following
1943 conditions are met:

1944 1. The county-owned hospital fully meets all
1945 applicable criteria and standards required to obtain a certificate
1946 of need for the nursing facility beds; and

1947 2. The county-owned hospital's qualifications
1948 for the certificate of need, as shown in its application and as
1949 determined by the department, are at least equal to the
1950 qualifications of the other applicants for the certificate of
1951 need.

1952 (r) (i) Beginning on July 1, 1999, the State
1953 Department of Health shall issue certificates of need during each
1954 of the next two (2) fiscal years for the construction or expansion
1955 of nursing facility beds or the conversion of other beds to



1956 nursing facility beds in each of the four (4) Long-Term Care
1957 Planning Districts designated in the fiscal year 1999 State Health
1958 Plan, to provide care exclusively to patients with Alzheimer's
1959 disease.

1960 (ii) Not more than twenty (20) beds may be
1961 authorized by any certificate of need issued under this paragraph
1962 (r), and not more than a total of sixty (60) beds may be
1963 authorized in any Long-Term Care Planning District by all
1964 certificates of need issued under this paragraph (r). However,
1965 the total number of beds that may be authorized by all
1966 certificates of need issued under this paragraph (r) during any
1967 fiscal year shall not exceed one hundred twenty (120) beds, and
1968 the total number of beds that may be authorized in any Long-Term
1969 Care Planning District during any fiscal year shall not exceed
1970 forty (40) beds. Of the certificates of need that are issued for
1971 each Long-Term Care Planning District during the next two (2)
1972 fiscal years, at least one (1) shall be issued for beds in the
1973 northern part of the district, at least one (1) shall be issued
1974 for beds in the central part of the district, and at least one (1)
1975 shall be issued for beds in the southern part of the district.

1976 (iii) The State Department of Health, in
1977 consultation with the Department of Mental Health and the Division
1978 of Medicaid, shall develop and prescribe the staffing levels,
1979 space requirements and other standards and requirements that must
1980 be met with regard to the nursing facility beds authorized under
1981 this paragraph (r) to provide care exclusively to patients with
1982 Alzheimer's disease.

1983 (3) The State Department of Health may grant approval for
1984 and issue certificates of need to any person proposing the new
1985 construction of, addition to, conversion of beds of or expansion
1986 of any health care facility defined in subparagraph (x)
1987 (psychiatric residential treatment facility) of Section
1988 41-7-173(h). The total number of beds which may be authorized by



1989 such certificates of need shall not exceed three hundred
1990 thirty-four (334) beds for the entire state.

1991 (a) Of the total number of beds authorized under this
1992 subsection, the department shall issue a certificate of need to a
1993 privately-owned psychiatric residential treatment facility in
1994 Simpson County for the conversion of sixteen (16) intermediate
1995 care facility for the mentally retarded (ICF-MR) beds to
1996 psychiatric residential treatment facility beds, provided that
1997 facility agrees in writing that the facility shall give priority
1998 for the use of those sixteen (16) beds to Mississippi residents
1999 who are presently being treated in out-of-state facilities.

2000 (b) Of the total number of beds authorized under this
2001 subsection, the department may issue a certificate or certificates
2002 of need for the construction or expansion of psychiatric
2003 residential treatment facility beds or the conversion of other
2004 beds to psychiatric residential treatment facility beds in Warren
2005 County, not to exceed sixty (60) psychiatric residential treatment
2006 facility beds, provided that the facility agrees in writing that
2007 no more than thirty (30) of the beds at the psychiatric
2008 residential treatment facility will be certified for participation
2009 in the Medicaid program (Section 43-13-101 et seq.) for the use of
2010 any patients other than those who are participating only in the
2011 Medicaid program of another state, and that no claim will be
2012 submitted to the Division of Medicaid for Medicaid reimbursement
2013 for more than thirty (30) patients in the psychiatric residential
2014 treatment facility in any day or for any patient in the
2015 psychiatric residential treatment facility who is in a bed that is
2016 not Medicaid-certified. This written agreement by the recipient
2017 of the certificate of need shall be a condition of the issuance of
2018 the certificate of need under this paragraph, and the agreement
2019 shall be fully binding on any subsequent owner of the psychiatric
2020 residential treatment facility if the ownership of the facility is
2021 transferred at any time after the issuance of the certificate of



2022 need. After this written agreement is executed, the Division of
2023 Medicaid and the State Department of Health shall not certify more
2024 than thirty (30) of the beds in the psychiatric residential
2025 treatment facility for participation in the Medicaid program for
2026 the use of any patients other than those who are participating
2027 only in the Medicaid program of another state. If the psychiatric
2028 residential treatment facility violates the terms of the written
2029 agreement by admitting or keeping in the facility on a regular or
2030 continuing basis more than thirty (30) patients who are
2031 participating in the Mississippi Medicaid program, the State
2032 Department of Health shall revoke the license of the facility, at
2033 the time that the department determines, after a hearing complying
2034 with due process, that the facility has violated the condition
2035 upon which the certificate of need was issued, as provided in this
2036 paragraph and in the written agreement.

2037 The State Department of Health, on or before July 1, 2002,
2038 shall transfer the certificate of need authorized under the
2039 authority of this paragraph (b), or reissue the certificate of
2040 need if it has expired, to River Region Health System.

2041 (c) Of the total number of beds authorized under this
2042 subsection, the department shall issue a certificate of need to a
2043 hospital currently operating Medicaid-certified acute psychiatric
2044 beds for adolescents in DeSoto County, for the establishment of a
2045 forty-bed psychiatric residential treatment facility in DeSoto
2046 County, provided that the hospital agrees in writing (i) that the
2047 hospital shall give priority for the use of those forty (40) beds
2048 to Mississippi residents who are presently being treated in
2049 out-of-state facilities, and (ii) that no more than fifteen (15)
2050 of the beds at the psychiatric residential treatment facility will
2051 be certified for participation in the Medicaid program (Section
2052 43-13-101 et seq.), and that no claim will be submitted for
2053 Medicaid reimbursement for more than fifteen (15) patients in the
2054 psychiatric residential treatment facility in any day or for any



2055 patient in the psychiatric residential treatment facility who is
2056 in a bed that is not Medicaid-certified. This written agreement
2057 by the recipient of the certificate of need shall be a condition
2058 of the issuance of the certificate of need under this paragraph,
2059 and the agreement shall be fully binding on any subsequent owner
2060 of the psychiatric residential treatment facility if the ownership
2061 of the facility is transferred at any time after the issuance of
2062 the certificate of need. After this written agreement is
2063 executed, the Division of Medicaid and the State Department of
2064 Health shall not certify more than fifteen (15) of the beds in the
2065 psychiatric residential treatment facility for participation in
2066 the Medicaid program. If the psychiatric residential treatment
2067 facility violates the terms of the written agreement by admitting
2068 or keeping in the facility on a regular or continuing basis more
2069 than fifteen (15) patients who are participating in the Medicaid
2070 program, the State Department of Health shall revoke the license
2071 of the facility, at the time that the department determines, after
2072 a hearing complying with due process, that the facility has
2073 violated the condition upon which the certificate of need was
2074 issued, as provided in this paragraph and in the written
2075 agreement.

2076 (d) Of the total number of beds authorized under this
2077 subsection, the department may issue a certificate or certificates
2078 of need for the construction or expansion of psychiatric
2079 residential treatment facility beds or the conversion of other
2080 beds to psychiatric treatment facility beds, not to exceed thirty
2081 (30) psychiatric residential treatment facility beds, in either
2082 Alcorn, Tishomingo, Prentiss, Lee, Itawamba, Monroe, Chickasaw,
2083 Pontotoc, Calhoun, Lafayette, Union, Benton or Tippah County.

2084 (e) Of the total number of beds authorized under this
2085 subsection (3) the department shall issue a certificate of need to
2086 a privately-owned, nonprofit psychiatric residential treatment
2087 facility in Hinds County for an eight-bed expansion of the



2088 facility, provided that the facility agrees in writing that the
2089 facility shall give priority for the use of those eight (8) beds
2090 to Mississippi residents who are presently being treated in
2091 out-of-state facilities.

2092 (f) The department shall issue a certificate of need to
2093 a one-hundred-thirty-four-bed specialty hospital located on
2094 twenty-nine and forty-four one-hundredths (29.44) commercial acres
2095 at 5900 Highway 39 North in Meridian (Lauderdale County),
2096 Mississippi, for the addition, construction or expansion of
2097 child/adolescent psychiatric residential treatment facility beds
2098 in Lauderdale County. As a condition of issuance of the
2099 certificate of need under this paragraph, the facility shall give
2100 priority in admissions to the child/adolescent psychiatric
2101 residential treatment facility beds authorized under this
2102 paragraph to patients who otherwise would require out-of-state
2103 placement. The Division of Medicaid, in conjunction with the
2104 Department of Human Services, shall furnish the facility a list of
2105 all out-of-state patients on a quarterly basis. Furthermore,
2106 notice shall also be provided to the parent, custodial parent or
2107 guardian of each out-of-state patient notifying them of the
2108 priority status granted by this paragraph. For purposes of this
2109 paragraph, the provisions of Section 41-7-193(1) requiring
2110 substantial compliance with the projection of need as reported in
2111 the current State Health Plan are waived. The total number of
2112 child/adolescent psychiatric residential treatment facility beds
2113 that may be authorized under the authority of this paragraph shall
2114 be sixty (60) beds. There shall be no prohibition or restrictions
2115 on participation in the Medicaid program (Section 43-13-101 et
2116 seq.) for the person receiving the certificate of need authorized
2117 under this paragraph or for the beds converted pursuant to the
2118 authority of that certificate of need.

2119 (4) (a) From and after July 1, 1993, the department shall
2120 not issue a certificate of need to any person for the new



2121 construction of any hospital, psychiatric hospital or chemical
2122 dependency hospital that will contain any child/adolescent
2123 psychiatric or child/adolescent chemical dependency beds, or for
2124 the conversion of any other health care facility to a hospital,
2125 psychiatric hospital or chemical dependency hospital that will
2126 contain any child/adolescent psychiatric or child/adolescent
2127 chemical dependency beds, or for the addition of any
2128 child/adolescent psychiatric or child/adolescent chemical
2129 dependency beds in any hospital, psychiatric hospital or chemical
2130 dependency hospital, or for the conversion of any beds of another
2131 category in any hospital, psychiatric hospital or chemical
2132 dependency hospital to child/adolescent psychiatric or
2133 child/adolescent chemical dependency beds, except as hereinafter
2134 authorized:

2135 (i) The department may issue certificates of need
2136 to any person for any purpose described in this subsection,
2137 provided that the hospital, psychiatric hospital or chemical
2138 dependency hospital does not participate in the Medicaid program
2139 (Section 43-13-101 et seq.) at the time of the application for the
2140 certificate of need and the owner of the hospital, psychiatric
2141 hospital or chemical dependency hospital agrees in writing that
2142 the hospital, psychiatric hospital or chemical dependency hospital
2143 will not at any time participate in the Medicaid program or admit
2144 or keep any patients who are participating in the Medicaid program
2145 in the hospital, psychiatric hospital or chemical dependency
2146 hospital. This written agreement by the recipient of the
2147 certificate of need shall be fully binding on any subsequent owner
2148 of the hospital, psychiatric hospital or chemical dependency
2149 hospital, if the ownership of the facility is transferred at any
2150 time after the issuance of the certificate of need. Agreement
2151 that the hospital, psychiatric hospital or chemical dependency
2152 hospital will not participate in the Medicaid program shall be a
2153 condition of the issuance of a certificate of need to any person



2154 under this subparagraph (a)(i), and if such hospital, psychiatric
2155 hospital or chemical dependency hospital at any time after the
2156 issuance of the certificate of need, regardless of the ownership
2157 of the facility, participates in the Medicaid program or admits or
2158 keeps any patients in the hospital, psychiatric hospital or
2159 chemical dependency hospital who are participating in the Medicaid
2160 program, the State Department of Health shall revoke the
2161 certificate of need, if it is still outstanding, and shall deny or
2162 revoke the license of the hospital, psychiatric hospital or
2163 chemical dependency hospital, at the time that the department
2164 determines, after a hearing complying with due process, that the
2165 hospital, psychiatric hospital or chemical dependency hospital has
2166 failed to comply with any of the conditions upon which the
2167 certificate of need was issued, as provided in this subparagraph
2168 and in the written agreement by the recipient of the certificate
2169 of need.

2170 (ii) The department may issue a certificate of
2171 need for the conversion of existing beds in a county hospital in
2172 Choctaw County from acute care beds to child/adolescent chemical
2173 dependency beds. For purposes of this subparagraph, the
2174 provisions of Section 41-7-193(1) requiring substantial compliance
2175 with the projection of need as reported in the current State
2176 Health Plan is waived. The total number of beds that may be
2177 authorized under authority of this subparagraph shall not exceed
2178 twenty (20) beds. There shall be no prohibition or restrictions
2179 on participation in the Medicaid program (Section 43-13-101 et
2180 seq.) for the hospital receiving the certificate of need
2181 authorized under this subparagraph (a)(ii) or for the beds
2182 converted pursuant to the authority of that certificate of need.

2183 (iii) The department may issue a certificate or
2184 certificates of need for the construction or expansion of
2185 child/adolescent psychiatric beds or the conversion of other beds
2186 to child/adolescent psychiatric beds in Warren County. For



2187 purposes of this subparagraph, the provisions of Section
2188 41-7-193(1) requiring substantial compliance with the projection
2189 of need as reported in the current State Health Plan are waived.
2190 The total number of beds that may be authorized under the
2191 authority of this subparagraph shall not exceed twenty (20) beds.
2192 There shall be no prohibition or restrictions on participation in
2193 the Medicaid program (Section 43-13-101 et seq.) for the person
2194 receiving the certificate of need authorized under this
2195 subparagraph (a)(iii) or for the beds converted pursuant to the
2196 authority of that certificate of need.

2197 If by January 1, 2002, there has been no significant
2198 commencement of construction of the beds authorized under this
2199 subparagraph (a)(iii), or no significant action taken to convert
2200 existing beds to the beds authorized under this subparagraph, then
2201 the certificate of need that was previously issued under this
2202 subparagraph shall expire. If the previously issued certificate
2203 of need expires, the department may accept applications for
2204 issuance of another certificate of need for the beds authorized
2205 under this subparagraph, and may issue a certificate of need to
2206 authorize the construction, expansion or conversion of the beds
2207 authorized under this subparagraph.

2208 (iv) The department shall issue a certificate of
2209 need to the Region 7 Mental Health/Retardation Commission for the
2210 construction or expansion of child/adolescent psychiatric beds or
2211 the conversion of other beds to child/adolescent psychiatric beds
2212 in any of the counties served by the commission. For purposes of
2213 this subparagraph, the provisions of Section 41-7-193(1) requiring
2214 substantial compliance with the projection of need as reported in
2215 the current State Health Plan is waived. The total number of beds
2216 that may be authorized under the authority of this subparagraph
2217 shall not exceed twenty (20) beds. There shall be no prohibition
2218 or restrictions on participation in the Medicaid program (Section
2219 43-13-101 et seq.) for the person receiving the certificate of



2220 need authorized under this subparagraph (a)(iv) or for the beds
2221 converted pursuant to the authority of that certificate of need.

2222 (v) The department may issue a certificate of need
2223 to any county hospital located in Leflore County for the
2224 construction or expansion of adult psychiatric beds or the
2225 conversion of other beds to adult psychiatric beds, not to exceed
2226 twenty (20) beds, provided that the recipient of the certificate
2227 of need agrees in writing that the adult psychiatric beds will not
2228 at any time be certified for participation in the Medicaid program
2229 and that the hospital will not admit or keep any patients who are
2230 participating in the Medicaid program in any of such adult
2231 psychiatric beds. This written agreement by the recipient of the
2232 certificate of need shall be fully binding on any subsequent owner
2233 of the hospital if the ownership of the hospital is transferred at
2234 any time after the issuance of the certificate of need. Agreement
2235 that the adult psychiatric beds will not be certified for
2236 participation in the Medicaid program shall be a condition of the
2237 issuance of a certificate of need to any person under this
2238 subparagraph (a)(v), and if such hospital at any time after the
2239 issuance of the certificate of need, regardless of the ownership
2240 of the hospital, has any of such adult psychiatric beds certified
2241 for participation in the Medicaid program or admits or keeps any
2242 Medicaid patients in such adult psychiatric beds, the State
2243 Department of Health shall revoke the certificate of need, if it
2244 is still outstanding, and shall deny or revoke the license of the
2245 hospital at the time that the department determines, after a
2246 hearing complying with due process, that the hospital has failed
2247 to comply with any of the conditions upon which the certificate of
2248 need was issued, as provided in this subparagraph and in the
2249 written agreement by the recipient of the certificate of need.

2250 (vi) The department may issue a certificate or
2251 certificates of need for the expansion of child psychiatric beds
2252 or the conversion of other beds to child psychiatric beds at the



2253 University of Mississippi Medical Center. For purposes of this
2254 subparagraph (a)(vi), the provision of Section 41-7-193(1)
2255 requiring substantial compliance with the projection of need as
2256 reported in the current State Health Plan is waived. The total
2257 number of beds that may be authorized under the authority of this
2258 subparagraph (a)(vi) shall not exceed fifteen (15) beds. There
2259 shall be no prohibition or restrictions on participation in the
2260 Medicaid program (Section 43-13-101 et seq.) for the hospital
2261 receiving the certificate of need authorized under this
2262 subparagraph (a)(vi) or for the beds converted pursuant to the
2263 authority of that certificate of need.

2264 (b) From and after July 1, 1990, no hospital,
2265 psychiatric hospital or chemical dependency hospital shall be
2266 authorized to add any child/adolescent psychiatric or
2267 child/adolescent chemical dependency beds or convert any beds of
2268 another category to child/adolescent psychiatric or
2269 child/adolescent chemical dependency beds without a certificate of
2270 need under the authority of subsection (1)(c) of this section.

2271 (5) The department may issue a certificate of need to a
2272 county hospital in Winston County for the conversion of fifteen
2273 (15) acute care beds to geriatric psychiatric care beds.

2274 (6) The State Department of Health shall issue a certificate
2275 of need to a Mississippi corporation qualified to manage a
2276 long-term care hospital as defined in Section 41-7-173(h)(xii) in
2277 Harrison County, not to exceed eighty (80) beds, including any
2278 necessary renovation or construction required for licensure and
2279 certification, provided that the recipient of the certificate of
2280 need agrees in writing that the long-term care hospital will not
2281 at any time participate in the Medicaid program (Section 43-13-101
2282 et seq.) or admit or keep any patients in the long-term care
2283 hospital who are participating in the Medicaid program. This
2284 written agreement by the recipient of the certificate of need
2285 shall be fully binding on any subsequent owner of the long-term



2286 care hospital, if the ownership of the facility is transferred at
2287 any time after the issuance of the certificate of need. Agreement
2288 that the long-term care hospital will not participate in the
2289 Medicaid program shall be a condition of the issuance of a
2290 certificate of need to any person under this subsection (6), and
2291 if such long-term care hospital at any time after the issuance of
2292 the certificate of need, regardless of the ownership of the
2293 facility, participates in the Medicaid program or admits or keeps
2294 any patients in the facility who are participating in the Medicaid
2295 program, the State Department of Health shall revoke the
2296 certificate of need, if it is still outstanding, and shall deny or
2297 revoke the license of the long-term care hospital, at the time
2298 that the department determines, after a hearing complying with due
2299 process, that the facility has failed to comply with any of the
2300 conditions upon which the certificate of need was issued, as
2301 provided in this subsection and in the written agreement by the
2302 recipient of the certificate of need. For purposes of this
2303 subsection, the provision of Section 41-7-193(1) requiring
2304 substantial compliance with the projection of need as reported in
2305 the current State Health Plan is hereby waived.

2306 (7) The State Department of Health may issue a certificate
2307 of need to any hospital in the state to utilize a portion of its
2308 beds for the "swing-bed" concept. Any such hospital must be in
2309 conformance with the federal regulations regarding such swing-bed
2310 concept at the time it submits its application for a certificate
2311 of need to the State Department of Health, except that such
2312 hospital may have more licensed beds or a higher average daily
2313 census (ADC) than the maximum number specified in federal
2314 regulations for participation in the swing-bed program. Any
2315 hospital meeting all federal requirements for participation in the
2316 swing-bed program which receives such certificate of need shall
2317 render services provided under the swing-bed concept to any
2318 patient eligible for Medicare (Title XVIII of the Social Security



2319 Act) who is certified by a physician to be in need of such
2320 services, and no such hospital shall permit any patient who is
2321 eligible for both Medicaid and Medicare or eligible only for
2322 Medicaid to stay in the swing beds of the hospital for more than
2323 thirty (30) days per admission unless the hospital receives prior
2324 approval for such patient from the Division of Medicaid, Office of
2325 the Governor. Any hospital having more licensed beds or a higher
2326 average daily census (ADC) than the maximum number specified in
2327 federal regulations for participation in the swing-bed program
2328 which receives such certificate of need shall develop a procedure
2329 to insure that before a patient is allowed to stay in the swing
2330 beds of the hospital, there are no vacant nursing home beds
2331 available for that patient located within a fifty-mile radius of
2332 the hospital. When any such hospital has a patient staying in the
2333 swing beds of the hospital and the hospital receives notice from a
2334 nursing home located within such radius that there is a vacant bed
2335 available for that patient, the hospital shall transfer the
2336 patient to the nursing home within a reasonable time after receipt
2337 of the notice. Any hospital which is subject to the requirements
2338 of the two (2) preceding sentences of this subsection may be
2339 suspended from participation in the swing-bed program for a
2340 reasonable period of time by the State Department of Health if the
2341 department, after a hearing complying with due process, determines
2342 that the hospital has failed to comply with any of those
2343 requirements.

2344 (8) The Department of Health shall not grant approval for or
2345 issue a certificate of need to any person proposing the new
2346 construction of, addition to or expansion of a health care
2347 facility as defined in subparagraph (viii) of Section 41-7-173(h).

2348 (9) The Department of Health shall not grant approval for or
2349 issue a certificate of need to any person proposing the
2350 establishment of, or expansion of the currently approved territory
2351 of, or the contracting to establish a home office, subunit or



2352 branch office within the space operated as a health care facility
2353 as defined in Section 41-7-173(h) (i) through (viii) by a health
2354 care facility as defined in subparagraph (ix) of Section
2355 41-7-173(h).

2356 (10) Health care facilities owned and/or operated by the
2357 state or its agencies are exempt from the restraints in this
2358 section against issuance of a certificate of need if such addition
2359 or expansion consists of repairing or renovation necessary to
2360 comply with the state licensure law. This exception shall not
2361 apply to the new construction of any building by such state
2362 facility. This exception shall not apply to any health care
2363 facilities owned and/or operated by counties, municipalities,
2364 districts, unincorporated areas, other defined persons, or any
2365 combination thereof.

2366 (11) The new construction, renovation or expansion of or
2367 addition to any health care facility defined in subparagraph (ii)
2368 (psychiatric hospital), subparagraph (iv) (skilled nursing
2369 facility), subparagraph (vi) (intermediate care facility),
2370 subparagraph (viii) (intermediate care facility for the mentally
2371 retarded) and subparagraph (x) (psychiatric residential treatment
2372 facility) of Section 41-7-173(h) which is owned by the State of
2373 Mississippi and under the direction and control of the State
2374 Department of Mental Health, and the addition of new beds or the
2375 conversion of beds from one category to another in any such
2376 defined health care facility which is owned by the State of
2377 Mississippi and under the direction and control of the State
2378 Department of Mental Health, shall not require the issuance of a
2379 certificate of need under Section 41-7-171 et seq.,
2380 notwithstanding any provision in Section 41-7-171 et seq. to the
2381 contrary.

2382 (12) The new construction, renovation or expansion of or
2383 addition to any veterans homes or domiciliaries for eligible
2384 veterans of the State of Mississippi as authorized under Section



2385 35-1-19 shall not require the issuance of a certificate of need,
2386 notwithstanding any provision in Section 41-7-171 et seq. to the
2387 contrary.

2388 (13) The new construction of a nursing facility or nursing
2389 facility beds or the conversion of other beds to nursing facility
2390 beds shall not require the issuance of a certificate of need,
2391 notwithstanding any provision in Section 41-7-171 et seq. to the
2392 contrary, if the conditions of this subsection are met.

2393 (a) Before any construction or conversion may be
2394 undertaken without a certificate of need, the owner of the nursing
2395 facility, in the case of an existing facility, or the applicant to
2396 construct a nursing facility, in the case of new construction,
2397 first must file a written notice of intent and sign a written
2398 agreement with the State Department of Health that the entire
2399 nursing facility will not at any time participate in or have any
2400 beds certified for participation in the Medicaid program (Section
2401 43-13-101 et seq.), will not admit or keep any patients in the
2402 nursing facility who are participating in the Medicaid program,
2403 and will not submit any claim for Medicaid reimbursement for any
2404 patient in the facility. This written agreement by the owner or
2405 applicant shall be a condition of exercising the authority under
2406 this subsection without a certificate of need, and the agreement
2407 shall be fully binding on any subsequent owner of the nursing
2408 facility if the ownership of the facility is transferred at any
2409 time after the agreement is signed. After the written agreement
2410 is signed, the Division of Medicaid and the State Department of
2411 Health shall not certify any beds in the nursing facility for
2412 participation in the Medicaid program. If the nursing facility
2413 violates the terms of the written agreement by participating in
2414 the Medicaid program, having any beds certified for participation
2415 in the Medicaid program, admitting or keeping any patient in the
2416 facility who is participating in the Medicaid program, or
2417 submitting any claim for Medicaid reimbursement for any patient in



2418 the facility, the State Department of Health shall revoke the
2419 license of the nursing facility at the time that the department
2420 determines, after a hearing complying with due process, that the
2421 facility has violated the terms of the written agreement.

2422 (b) For the purposes of this subsection, participation
2423 in the Medicaid program by a nursing facility includes Medicaid
2424 reimbursement of coinsurance and deductibles for recipients who
2425 are qualified Medicare beneficiaries and/or those who are dually
2426 eligible. Any nursing facility exercising the authority under
2427 this subsection may not bill or submit a claim to the Division of
2428 Medicaid for services to qualified Medicare beneficiaries and/or
2429 those who are dually eligible.

2430 (c) The new construction of a nursing facility or
2431 nursing facility beds or the conversion of other beds to nursing
2432 facility beds described in this section must be either a part of a
2433 completely new continuing care retirement community, as described
2434 in the latest edition of the Mississippi State Health Plan, or an
2435 addition to existing personal care and independent living
2436 components, and so that the completed project will be a continuing
2437 care retirement community, containing (i) independent living
2438 accommodations, (ii) personal care beds, and (iii) the nursing
2439 home facility beds. The three (3) components must be located on a
2440 single site and be operated as one (1) inseparable facility. The
2441 nursing facility component must contain a minimum of thirty (30)
2442 beds. Any nursing facility beds authorized by this section will
2443 not be counted against the bed need set forth in the State Health
2444 Plan, as identified in Section 41-7-171 et seq.

2445 This subsection (13) shall stand repealed from and after July
2446 1, 2005.

2447 (14) The State Department of Health shall issue a
2448 certificate of need to any hospital which is currently licensed
2449 for two hundred fifty (250) or more acute care beds and is located
2450 in any general hospital service area not having a comprehensive



2451 cancer center, for the establishment and equipping of such a
2452 center which provides facilities and services for outpatient
2453 radiation oncology therapy, outpatient medical oncology therapy,
2454 and appropriate support services including the provision of
2455 radiation therapy services. The provision of Section 41-7-193(1)
2456 regarding substantial compliance with the projection of need as
2457 reported in the current State Health Plan is waived for the
2458 purpose of this subsection.

2459 (15) The State Department of Health may authorize the
2460 transfer of hospital beds, not to exceed sixty (60) beds, from the
2461 North Panola Community Hospital to the South Panola Community
2462 Hospital. The authorization for the transfer of those beds shall
2463 be exempt from the certificate of need review process.

2464 (16) Nothing in this section or in any other provision of
2465 Section 41-7-171 et seq. shall prevent any nursing facility from
2466 designating an appropriate number of existing beds in the facility
2467 as beds for providing care exclusively to patients with
2468 Alzheimer's disease.

2469 (17) Beginning July 1, 2003, and annually thereafter, the
2470 State Department of Health shall revise the State Health Plan to
2471 include home- and community-based services located in the health
2472 service districts as authorized alternatives to institutional
2473 nursing facility services in determining the need for such
2474 additional nursing facility beds.

2475 **SECTION 8.** This act shall take effect and be in force from
2476 and after its passage.

