MISSISSIPPI LEGISLATURE REGULAR SESSION 2003

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

To: Public Health and Welfare; Appropriations

COMMITTEE SUBSTITUTE
FOR
SENATE BILL NO. 2346

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) Repealed.

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

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

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

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

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

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

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

(4) [Deleted]

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

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

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

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

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

(9) Individuals who are:

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

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

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

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

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

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

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

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

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

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

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

* * *

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

(14) [Deleted]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) Inpatient hospital services.

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

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

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

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

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

(3) Laboratory and x-ray services.

(4) Nursing facility services.

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

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

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

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

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

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

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

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

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

* * *

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

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

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

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

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

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

(b) Repealed.

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

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

* * *

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

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

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

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

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

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

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

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

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

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

* * *

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

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

* * *

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

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

(12) Intermediate care facility services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

state early intervention funds available that will be utilized as a certified match for Medicaid matching funds. Those funds then shall be used to provide expanded targeted case management services for Medicaid eligible children with special needs who are eligible for the state's early intervention system. Qualifications for persons providing service coordination shall be determined by the State Department of Health and the Division of Medicaid.

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

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

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

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

(24) [Deleted]

(25) [Deleted]

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

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

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

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

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

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

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

(33) Podiatrist services.

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

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

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

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

(37) [Deleted]

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

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

(40) [Deleted]

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

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

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

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

(44) Nursing facility services for the severely disabled.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This section shall stand repealed on July 1, 2004.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(ii) The State Veterans Affairs Board;

(iii) The University of Mississippi Medical Center; or

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

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

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

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

(ii) The University of Mississippi Medical Center;

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

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

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

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

(ii) The University of Mississippi Medical Center; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Open heart surgery services;

(ii) Cardiac catheterization services;

(iii) Comprehensive inpatient rehabilitation services;

(iv) Licensed psychiatric services;

(v) Licensed chemical dependency services;

(vi) Radiation therapy services;

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

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

(ix) Home health services;

(x) Swing-bed services;

(xi) Ambulatory surgical services;

(xii) Magnetic resonance imaging services;

(xiii) Extracorporeal shock wave lithotripsy services;

(xiv) Long-term care hospital services;

(xv) Positron Emission Tomography (PET) services;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

need. After this written agreement is executed, the Division of Medicaid and the State Department of Health shall not certify any of the beds in the nursing facility for participation in the Medicaid program. If the nursing facility violates the terms of the written agreement by admitting or keeping in the nursing facility on a regular or continuing basis any patients who are participating in the Medicaid program, the State Department of Health shall revoke the license of the nursing facility, at the time that the department determines, after a hearing complying with due process, that the nursing facility has violated the condition upon which the certificate of need was issued, as provided in this paragraph and in the written agreement. If the certificate of need authorized under this paragraph is not issued within twelve (12) months after July 1, 2001, the department shall deny the application for the certificate of need and shall not issue the certificate of need at any time after the twelve-month period, unless the issuance is contested. If the certificate of need is issued and substantial construction of the nursing facility beds has not commenced within eighteen (18) months after July 1, 2001, the State Department of Health, after a hearing complying with due process, shall revoke the certificate of need if it is still outstanding, and the department shall not issue a license for the nursing facility at any time after the eighteen-month period. Provided, however, that if the issuance of the certificate of need is contested, the department shall require substantial construction of the nursing facility beds within six (6) months after final adjudication on the issuance of the certificate of need.

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

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

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

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

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

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

the certificate of need, regardless of the ownership of the facility, participates in the Medicaid program or admits or keeps any patients in the facility who are participating in the Medicaid program, the State Department of Health shall revoke the certificate of need, if it is still outstanding, and shall deny or revoke the license of the skilled nursing facility, at the time that the department determines, after a hearing complying with due process, that the facility has failed to comply with any of the conditions upon which the certificate of need was issued, as provided in this paragraph and in the written agreement by the recipient of the certificate of need. The provision of Section 43-7-193(1) regarding substantial compliance of the projection of need as reported in the current State Health Plan is waived for the purposes of this paragraph. If the certificate of need authorized under this paragraph is not issued within twelve (12) months after July 1, 1998, the department shall deny the application for the certificate of need and shall not issue the certificate of need at any time after the twelve-month period, unless the issuance is contested. If the certificate of need is issued and substantial construction of the nursing facility beds has not commenced within eighteen (18) months after July 1, 1998, the State Department of Health, after a hearing complying with due process, shall revoke the certificate of need if it is still outstanding, and the department shall not issue a license for the nursing facility at any time after the eighteen-month period. Provided, however, that if the issuance of the certificate of need is contested, the department shall require substantial construction of the nursing facility beds within six (6) months after final adjudication on the issuance of the certificate of need.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

construction of any hospital, psychiatric hospital or chemical dependency hospital that will contain any child/adolescent psychiatric or child/adolescent chemical dependency beds, or for the conversion of any other health care facility to a hospital, psychiatric hospital or chemical dependency hospital that will contain any child/adolescent psychiatric or child/adolescent chemical dependency beds, or for the addition of any child/adolescent psychiatric or child/adolescent chemical dependency beds in any hospital, psychiatric hospital or chemical dependency hospital, or for the conversion of any beds of another category in any hospital, psychiatric hospital or chemical dependency hospital to child/adolescent psychiatric or child/adolescent chemical dependency beds, except as hereinafter authorized:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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