

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

To: Public Health and
Welfare; Appropriations

SENATE BILL NO. 2346

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

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



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

54 43-13-115. Recipients of medical assistance shall be the
55 following persons only:

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

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

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

82 (4) [Deleted]

83 (5) A child born on or after October 1, 1984, to a
84 woman eligible for and receiving medical assistance under the



85 state plan on the date of the child's birth shall be deemed to
86 have applied for medical assistance and to have been found
87 eligible for such assistance under such plan on the date of such
88 birth and will remain eligible for such assistance for a period of
89 one (1) year so long as the child is a member of the woman's
90 household and the woman remains eligible for such assistance or
91 would be eligible for assistance if pregnant. The eligibility of
92 individuals covered in this paragraph shall be determined by the
93 State Department of Human Services and certified to the Division
94 of Medicaid.

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

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

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



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

125 (9) Individuals who are:

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

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

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

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

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



151 waiver that will allow flexibility in the benefit design for the
152 Disabled Children Living at Home eligibility category authorized
153 herein, and the division may establish an expenditure/enrollment
154 cap for this category. Nothing contained in this paragraph (10)
155 shall entitle an individual for benefits.

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

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

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

179 The eligibility of individuals covered under this paragraph
180 shall be determined by the Division of Medicaid, and such
181 individuals determined eligible shall receive Medicare
182 cost-sharing expenses only as more fully defined by the Medicare



183 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
184 1997.

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

192 * * *

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

195 (14) [Deleted]

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

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

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



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

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

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

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

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



249 benefits to which he or she is entitled under that other
250 provision, in addition to family planning services covered under
251 Section 43-13-117(13).

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

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

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

277 * * *

278 (23) Children certified by the Mississippi Department
279 of Human Services for whom the state and county human services
280 agency has custody and financial responsibility who are in foster
281 care on their eighteenth birthday as reported by the Mississippi



282 Department of Human Services shall be certified Medicaid eligible
283 by the Division of Medicaid until their twenty-first birthday.

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

294 * * *

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

297 43-13-117. Medicaid as authorized by this article shall
298 include payment of part or all of the costs, at the discretion of
299 the division or its successor, with approval of the Governor, of
300 the following types of care and services rendered to eligible
301 applicants who have been determined to be eligible for that care
302 and services, within the limits of state appropriations and
303 federal matching funds:

304 (1) Inpatient hospital services.

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

312 (b) From and after July 1, 1994, the Executive
313 Director of the Division of Medicaid shall amend the Mississippi
314 Title XIX Inpatient Hospital Reimbursement Plan to remove the



315 occupancy rate penalty from the calculation of the Medicaid
316 Capital Cost Component utilized to determine total hospital costs
317 allocated to the Medicaid program.

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

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

330 (3) Laboratory and x-ray services.

331 (4) Nursing facility services.

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

339 (b) From and after July 1, 1997, the division
340 shall implement the integrated case-mix payment and quality
341 monitoring system, which includes the fair rental system for
342 property costs and in which recapture of depreciation is
343 eliminated. The division may reduce the payment for hospital
344 leave and therapeutic home leave days to the lower of the case-mix
345 category as computed for the resident on leave using the
346 assessment being utilized for payment at that point in time, or a
347 case-mix score of 1.000 for nursing facilities, and shall compute



348 case-mix scores of residents so that only services provided at the
349 nursing facility are considered in calculating a facility's per
350 diem.

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

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

363 (d) When a facility of a category that does not
364 require a certificate of need for construction and that could not
365 be eligible for Medicaid reimbursement is constructed to nursing
366 facility specifications for licensure and certification, and the
367 facility is subsequently converted to a nursing facility under a
368 certificate of need that authorizes conversion only and the
369 applicant for the certificate of need was assessed an application
370 review fee based on capital expenditures incurred in constructing
371 the facility, the division shall allow reimbursement for capital
372 expenditures necessary for construction of the facility that were
373 incurred within the twenty-four (24) consecutive calendar months
374 immediately preceding the date that the certificate of need
375 authorizing the conversion was issued, to the same extent that
376 reimbursement would be allowed for construction of a new nursing
377 facility under a certificate of need that authorizes that
378 construction. The reimbursement authorized in this subparagraph
379 (d) may be made only to facilities the construction of which was
380 completed after June 30, 1989. Before the division shall be



381 authorized to make the reimbursement authorized in this
382 subparagraph (d), the division first must have received approval
383 from the Health Care Financing Administration of the United States
384 Department of Health and Human Services of the change in the state
385 Medicaid plan providing for the reimbursement.

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

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

401 * * *

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

406 (5) Periodic screening and diagnostic services for
407 individuals under age twenty-one (21) years as are needed to
408 identify physical and mental defects and to provide health care
409 treatment and other measures designed to correct or ameliorate
410 defects and physical and mental illness and conditions discovered
411 by the screening services regardless of whether these services are
412 included in the state plan. The division may include in its
413 periodic screening and diagnostic program those discretionary



414 services authorized under the federal regulations adopted to
415 implement Title XIX of the federal Social Security Act, as
416 amended. The division, in obtaining physical therapy services,
417 occupational therapy services, and services for individuals with
418 speech, hearing and language disorders, may enter into a
419 cooperative agreement with the State Department of Education for
420 the provision of those services to handicapped students by public
421 school districts using state funds that are provided from the
422 appropriation to the Department of Education to obtain federal
423 matching funds through the division. The division, in obtaining
424 medical and psychological evaluations for children in the custody
425 of the State Department of Human Services may enter into a
426 cooperative agreement with the State Department of Human Services
427 for the provision of those services using state funds that are
428 provided from the appropriation to the Department of Human
429 Services to obtain federal matching funds through the division.

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

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



447 (b) Repealed.

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

459 (9) (a) Legend and other drugs as may be determined by
460 the division. The division shall contract for full scope pharmacy
461 benefit management services and shall implement a preferred drug
462 list (PDL), a mail-order option and supplemental rebates and, if
463 feasible, shall enter into such contract(s) in conjunction with
464 the State and School Employees Health Insurance Plan for this and
465 other states in order to take advantage of coalition buying. The
466 division may implement a program of prior approval for drugs to
467 the extent permitted by law. The division shall allow seven (7)
468 prescriptions per month for each noninstitutionalized Medicaid
469 recipient. * * * The division shall not reimburse for any portion
470 of a prescription that exceeds a thirty-four-day supply of the
471 drug based on the daily dosage.

472 * * *

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

477 All claims for drugs for dually eligible Medicare/Medicaid
478 beneficiaries that are paid for by Medicare must be submitted to



479 Medicare for payment before they may be processed by the
480 division's on-line payment system.

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

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

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

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

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

503 The Medicaid provider shall not prescribe, the Medicaid
504 pharmacy shall not bill, and the division shall not reimburse for
505 name brand drugs if there are equally effective generic
506 equivalents available and if the generic equivalents are the least
507 expensive.

508 * * *

509 As used in this paragraph (9), "estimated acquisition cost"
510 means twenty percent (20%) less than the average wholesale price
511 for a drug.



512 The division shall develop a state Maximum Allowable Cost
513 (MAC) pricing schedule for selected drugs in order to reduce the
514 cost of the pharmacy program as soon as practicable after July 1,
515 2003.

516 * * *

517 (10) Dental care that is an adjunct to treatment of an
518 acute medical or surgical condition; services of oral surgeons and
519 dentists in connection with surgery related to the jaw or any
520 structure contiguous to the jaw or the reduction of any fracture
521 of the jaw or any facial bone; and emergency dental extractions
522 and treatment related thereto. On July 1, 1999, all fees for
523 dental care and surgery under authority of this paragraph (10)
524 shall be increased to one hundred sixty percent (160%) of the
525 amount of the reimbursement rate that was in effect on June 30,
526 1999. It is the intent of the Legislature to encourage more
527 dentists to participate in the Medicaid program.

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

537 (12) Intermediate care facility services.

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



544 Christmas, Thanksgiving, the day before Thanksgiving and the day
545 after Thanksgiving.

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

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

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



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

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



610 under any capitated managed care pilot program provided for under
611 paragraph (24) of this section.

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

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

631 (b) The division shall establish a Medicare Upper
632 Payment Limits Program, as defined in Section 1902(a)(30) of the
633 federal Social Security Act and any applicable federal
634 regulations, for hospitals, and may establish a Medicare Upper
635 Payments Limits Program for nursing facilities. The division
636 shall assess each hospital and, if the program is established for
637 nursing facilities, shall assess each nursing facility, for the
638 sole purpose of financing the state portion of the Medicare Upper
639 Payment Limits Program. This assessment shall be based on
640 Medicaid utilization, or other appropriate method consistent with
641 federal regulations, and will remain in effect as long as the
642 state participates in the Medicare Upper Payment Limits Program.



643 The division shall make additional reimbursement to hospitals and,
644 if the program is established for nursing facilities, shall make
645 additional reimbursement to nursing facilities, for the Medicare
646 Upper Payment Limits, as defined in Section 1902(a)(30) of the
647 federal Social Security Act and any applicable federal
648 regulations. This subparagraph (b) shall stand repealed from and
649 after July 1, 2005.

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

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

665 (b) Early intervention system services. The
666 division shall cooperate with the State Department of Health,
667 acting as lead agency, in the development and implementation of a
668 statewide system of delivery of early intervention services, under
669 Part C of the Individuals with Disabilities Education Act (IDEA).
670 The State Department of Health shall certify annually in writing
671 to the executive director of the division the dollar amount of
672 state early intervention funds available that will be utilized as
673 a certified match for Medicaid matching funds. Those funds then
674 shall be used to provide expanded targeted case management
675 services for Medicaid eligible children with special needs who are



676 eligible for the state's early intervention system.
677 Qualifications for persons providing service coordination shall be
678 determined by the State Department of Health and the Division of
679 Medicaid.

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

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

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

705 (23) Inpatient psychiatric services. Inpatient
706 psychiatric services to be determined by the division for
707 recipients under age twenty-one (21) that are provided under the
708 direction of a physician in an inpatient program in a licensed



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

717 (24) [Deleted]

718 (25) [Deleted]

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

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

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

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



742 department by a political subdivision or instrumentality of the
743 state and used to match federal funds under a cooperative
744 agreement between the division and the department, provided that
745 funds for these services are specifically appropriated to the
746 Department of Mental Health and/or transferred to the department
747 by a political subdivision or instrumentality of the state.

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

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

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

762 (33) Podiatrist services.

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

767 (35) Services and activities authorized in Sections
768 43-27-101 and 43-27-103, using state funds that are provided from
769 the appropriation to the State Department of Human Services and
770 used to match federal funds under a cooperative agreement between
771 the division and the department.

772 (36) Nonemergency transportation services for
773 Medicaid-eligible persons, to be provided by the Division of
774 Medicaid. The division may contract with additional entities to



775 administer nonemergency transportation services as it deems
776 necessary. All providers shall have a valid driver's license,
777 vehicle inspection sticker, valid vehicle license tags and a
778 standard liability insurance policy covering the vehicle. The
779 division may pay providers a flat fee based on mileage tiers, or
780 in the alternative, may reimburse on actual miles traveled. The
781 division may apply to the Center for Medicare and Medicaid
782 Services (CMS) for a worker to draw federal matching funds for
783 nonemergency transportation services as a covered service instead
784 of an administrative cost.

785 (37) [Deleted]

786 (38) Chiropractic services. A chiropractor's manual
787 manipulation of the spine to correct a subluxation, if x-ray
788 demonstrates that a subluxation exists and if the subluxation has
789 resulted in a neuromusculoskeletal condition for which
790 manipulation is appropriate treatment, and related spinal x-rays
791 performed to document these conditions. Reimbursement for
792 chiropractic services shall not exceed Seven Hundred Dollars
793 (\$700.00) per year per beneficiary.

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

798 (40) [Deleted]

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



807 funds under a cooperative agreement between the division and the
808 department.

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

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

826 (44) Nursing facility services for the severely
827 disabled.

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

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

835 (45) Physician assistant services. Services furnished
836 by a physician assistant who is licensed by the State Board of
837 Medical Licensure and is practicing with physician supervision
838 under regulations adopted by the board, under regulations adopted
839 by the division. Reimbursement for those services shall not



840 exceed ninety percent (90%) of the reimbursement rate for
841 comparable services rendered by a physician.

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

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

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

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

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

866 (49) The division shall establish copayments for all
867 Medicaid services for which copayments are allowable under federal
868 law or regulation, except for nonemergency transportation
869 services, and shall set the amount of the copayment for each of
870 those services at the maximum amount allowable under federal law
871 or regulation.



872 Notwithstanding any other provision of this article to the
873 contrary, the division shall reduce the rate of reimbursement to
874 providers for any service provided under this section by five
875 percent (5%) of the allowed amount for that service. However, the
876 reduction in the reimbursement rates required by this paragraph
877 shall not apply to inpatient hospital services, nursing facility
878 services, intermediate care facility services, psychiatric
879 residential treatment facility services, pharmacy services
880 provided under paragraph (9) of this section, or any service
881 provided by the University of Mississippi Medical Center or a
882 state agency, a state facility or a public agency that either
883 provides its own state match through intergovernmental transfer or
884 certification of funds to the division, or a service for which the
885 federal government sets the reimbursement methodology and rate.
886 In addition, the reduction in the reimbursement rates required by
887 this paragraph shall not apply to * * * home- and community-based
888 services programs * * *.

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

894 Notwithstanding any provision of this article, except as
895 authorized in the following paragraph and in Section 43-13-139,
896 neither (a) the limitations on quantity or frequency of use of or
897 the fees or charges for any of the care or services available to
898 recipients under this section, nor (b) the payments or rates of
899 reimbursement to providers rendering care or services authorized
900 under this section to recipients, may be increased, decreased or
901 otherwise changed from the levels in effect on July 1, 1999,
902 unless they are authorized by an amendment to this section by the
903 Legislature. However, the restriction in this paragraph shall not
904 prevent the division from changing the payments or rates of



905 reimbursement to providers without an amendment to this section
906 whenever those changes are required by federal law or regulation,
907 or whenever those changes are necessary to correct administrative
908 errors or omissions in calculating those payments or rates of
909 reimbursement.

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

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



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

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

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

945 43-13-107. (1) The Division of Medicaid is created in the
946 Office of the Governor and established to administer this article
947 and perform such other duties as are prescribed by law.

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

963 (b) The executive director, with the approval of the
964 Governor and subject to the rules and regulations of the State
965 Personnel Board, shall employ such professional, administrative,
966 stenographic, secretarial, clerical and technical assistance as
967 may be necessary to perform the duties required in administering
968 this article and fix the compensation therefor, all in accordance
969 with a state merit system meeting federal requirements when the
970 salary of the executive director is not set by law, that salary



971 shall be set by the State Personnel Board. No employees of the
972 Division of Medicaid shall be considered to be staff members of
973 the immediate Office of the Governor; however, the provisions of
974 Section 25-9-107(c) (xv) shall apply to the executive director and
975 other administrative heads of the division.

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

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

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

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

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

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

993 (c) The respective chairmen of the House Public Health
994 and Welfare Committee, the House Appropriations Committee, the
995 Senate Public Health and Welfare Committee and the Senate
996 Appropriations Committee, or their designees, one (1) member of
997 the State Senate appointed by the Lieutenant Governor and one (1)
998 member of the House of Representatives appointed by the Speaker of
999 the House, shall serve as ex officio nonvoting members of the
1000 advisory committee.

1001 (d) In addition to the committee members required by
1002 paragraph (b), the advisory committee shall consist of such other
1003 members as are necessary to meet the requirements of the federal



1004 regulation applicable to the advisory committee, who shall be
1005 appointed as provided in the federal regulation.

1006 (e) The chairmanship of the advisory committee shall
1007 alternate for twelve-month periods between the chairmen of the
1008 House and Senate Public Health and Welfare Committees, with the
1009 Chairman of the House Public Health and Welfare Committee serving
1010 as the first chairman.

1011 (f) The members of the advisory committee specified in
1012 paragraph (b) shall serve for terms that are concurrent with the
1013 terms of members of the Legislature, and any member appointed
1014 under paragraph (b) may be reappointed to the advisory committee.
1015 The members of the advisory committee specified in paragraph (b)
1016 shall serve without compensation, but shall receive reimbursement
1017 to defray actual expenses incurred in the performance of committee
1018 business as authorized by law. Legislators shall receive per diem
1019 and expenses which may be paid from the contingent expense funds
1020 of their respective houses in the same amounts as provided for
1021 committee meetings when the Legislature is not in session.

1022 (g) The advisory committee shall meet not less than
1023 quarterly, and advisory committee members shall be furnished
1024 written notice of the meetings at least ten (10) days before the
1025 date of the meeting.

1026 (h) The executive director shall submit to the advisory
1027 committee all amendments, modifications and changes to the state
1028 plan for the operation of the Medicaid program, for review by the
1029 advisory committee before the amendments, modifications or changes
1030 may be implemented by the division.

1031 (i) The advisory committee, among its duties and
1032 responsibilities, shall:

1033 (i) Advise the division with respect to
1034 amendments, modifications and changes to the state plan for the
1035 operation of the Medicaid program;



1036 (ii) Advise the division with respect to issues
1037 concerning receipt and disbursement of funds and eligibility for
1038 Medicaid;

1039 (iii) Advise the division with respect to
1040 determining the quantity, quality and extent of medical care
1041 provided under this article;

1042 (iv) Communicate the views of the medical care
1043 professions to the division and communicate the views of the
1044 division to the medical care professions;

1045 (v) Gather information on reasons that medical
1046 care providers do not participate in the Medicaid program and
1047 changes that could be made in the program to encourage more
1048 providers to participate in the Medicaid program, and advise the
1049 division with respect to encouraging physicians and other medical
1050 care providers to participate in the Medicaid program;

1051 (vi) Provide a written report on or before
1052 November 30 of each year to the Governor, Lieutenant Governor and
1053 Speaker of the House of Representatives.

1054 (4) (a) There is established a Drug Use Review Board, which
1055 shall be the board that is required by federal law to:

1056 (i) Review and initiate retrospective drug use,
1057 review including ongoing periodic examination of claims data and
1058 other records in order to identify patterns of fraud, abuse, gross
1059 overuse, or inappropriate or medically unnecessary care, among
1060 physicians, pharmacists and individuals receiving Medicaid
1061 benefits or associated with specific drugs or groups of drugs.

1062 (ii) Review and initiate ongoing interventions for
1063 physicians and pharmacists, targeted toward therapy problems or
1064 individuals identified in the course of retrospective drug use
1065 reviews.

1066 (iii) On an ongoing basis, assess data on drug use
1067 against explicit predetermined standards using the compendia and
1068 literature set forth in federal law and regulations.



1069 (b) The board shall consist of not less than twelve
1070 (12) members appointed by the Governor or his designee.

1071 (c) The board shall meet at least quarterly, and board
1072 members shall be furnished written notice of the meetings at least
1073 ten (10) days before the date of the meeting.

1074 (d) The board meetings shall be open to the public,
1075 members of the press, legislators and consumers. Additionally,
1076 all documents provided to board members shall be available to
1077 members of the Legislature in the same manner, and shall be made
1078 available to others for a reasonable fee for copying. However,
1079 patient confidentiality and provider confidentiality shall be
1080 protected by blinding patient names and provider names with
1081 numerical or other anonymous identifiers. The board meetings
1082 shall be subject to the Open Meetings Act (Section 25-41-1 et
1083 seq.). Board meetings conducted in violation of this section
1084 shall be deemed unlawful.

1085 (5) (a) There is established a Pharmacy and Therapeutics
1086 Committee, which shall be appointed by the Governor or his
1087 designee.

1088 (b) The committee shall meet at least quarterly, and
1089 committee members shall be furnished written notice of the
1090 meetings at least ten (10) days before the date of the meeting.

1091 (c) The committee meetings shall be open to the public,
1092 members of the press, legislators and consumers. Additionally,
1093 all documents provided to committee members shall be available to
1094 members of the Legislature in the same manner, and shall be made
1095 available to others for a reasonable fee for copying. However,
1096 patient confidentiality and provider confidentiality shall be
1097 protected by blinding patient names and provider names with
1098 numerical or other anonymous identifiers. The committee meetings
1099 shall be subject to the Open Meetings Act (Section 25-41-1 et
1100 seq.). Committee meetings conducted in violation of this section
1101 shall be deemed unlawful.



1102 (d) After a thirty-day public notice, the executive
1103 director or his or her designee shall present the division's
1104 recommendation regarding prior approval for a therapeutic class of
1105 drugs to the committee. However, in circumstances where the
1106 division deems it necessary for the health and safety of Medicaid
1107 beneficiaries, the division may present to the committee its
1108 recommendations regarding a particular drug without a thirty-day
1109 public notice. In making such presentation, the division shall
1110 state to the committee the circumstances which precipitate the
1111 need for the committee to review the status of a particular drug
1112 without a thirty-day public notice. The committee may determine
1113 whether or not to review the particular drug under the
1114 circumstances stated by the division without a thirty-day public
1115 notice. If the committee determines to review the status of the
1116 particular drug, it shall make its recommendations to the
1117 division, after which the division shall file such recommendations
1118 for a thirty-day public comment under the provisions of Section
1119 25-43-7(1), Mississippi Code of 1972.

1120 (e) Upon reviewing the information and recommendations,
1121 the committee shall forward a written recommendation approved by a
1122 majority of the committee to the executive director or his or her
1123 designee. The decisions of the committee regarding any
1124 limitations to be imposed on any drug or its use for a specified
1125 indication shall be based on sound clinical evidence found in
1126 labeling, drug compendia, and peer reviewed clinical literature
1127 pertaining to use of the drug in the relevant population.

1128 (f) Upon reviewing and considering all recommendations
1129 including recommendation of the committee, comments, and data, the
1130 executive director shall make a final determination whether to
1131 require prior approval of a therapeutic class of drugs, or modify
1132 existing prior approval requirements for a therapeutic class of
1133 drugs.



1134 (g) At least thirty (30) days before the executive
1135 director implements new or amended prior authorization decisions,
1136 written notice of the executive director's decision shall be
1137 provided to all prescribing Medicaid providers, all Medicaid
1138 enrolled pharmacies, and any other party who has requested the
1139 notification. However, notice given under Section 25-43-7(1) will
1140 substitute for and meet the requirement for notice under this
1141 subsection.

1142 (6) This section shall stand repealed on July 1, 2004.

1143 **SECTION 4.** Section 43-13-122, Mississippi Code of 1972, is
1144 amended as follows:

1145 43-13-122. (1) The division is authorize to apply to the
1146 Center for Medicare and Medicaid Services of the United States
1147 Department of Health and Human Services for waivers and research
1148 and demonstration grants * * *.

1149 (2) The division is further authorized to accept and expend
1150 any grants, donations or contributions from any public or private
1151 organization together with any additional federal matching funds
1152 that may accrue and including, but not limited to, one hundred
1153 percent (100%) federal grant funds or funds from any governmental
1154 entity or instrumentality thereof in furthering the purposes and
1155 objectives of the Mississippi Medicaid program, provided that such
1156 receipts and expenditures are reported and otherwise handled in
1157 accordance with the General Fund Stabilization Act. The
1158 Department of Finance and Administration is authorized to transfer
1159 monies to the division from special funds in the State Treasury in
1160 amounts not exceeding the amounts authorized in the appropriation
1161 to the division.

1162 **SECTION 5.** Section 43-13-145, Mississippi Code of 1972, is
1163 amended as follows:

1164 43-13-145. (1) (a) Upon each nursing facility and each
1165 intermediate care facility for the mentally retarded licensed by
1166 the State of Mississippi, there is levied an assessment in the



1167 amount of Four Dollars (\$4.00) per day for each licensed and/or
1168 certified bed of the facility. The division may apply for a
1169 waiver from the United States Secretary of Health and Human
1170 Services to exempt nonprofit, public, charitable or religious
1171 facilities from the assessment levied under this subsection, and
1172 if a waiver is granted, those facilities shall be exempt from any
1173 assessment levied under this subsection after the date that the
1174 division receives notice that the waiver has been granted.

1175 (b) A nursing facility or intermediate care facility
1176 for the mentally retarded is exempt from the assessment levied
1177 under this subsection if the facility is operated under the
1178 direction and control of:

1179 (i) The United States Veterans Administration or
1180 other agency or department of the United States government;

1181 (ii) The State Veterans Affairs Board;

1182 (iii) The University of Mississippi Medical
1183 Center; or

1184 (iv) A state agency or a state facility that
1185 either provides its own state match through intergovernmental
1186 transfer or certification of funds to the division.

1187 (2) (a) Upon each psychiatric residential treatment
1188 facility licensed by the State of Mississippi, there is levied an
1189 assessment in the amount of Three Dollars (\$3.00) per day for each
1190 licensed and/or certified bed of the facility.

1191 (b) A psychiatric residential treatment facility is
1192 exempt from the assessment levied under this subsection if the
1193 facility is operated under the direction and control of:

1194 (i) The United States Veterans Administration or
1195 other agency or department of the United States government;

1196 (ii) The University of Mississippi Medical Center;

1197 (iii) A state agency or a state facility that
1198 either provides its own state match through intergovernmental
1199 transfer or certification of funds to the division.



1200 (3) (a) Upon each hospital licensed by the State of
1201 Mississippi, there is levied an assessment in the amount of One
1202 Dollar and Fifty Cents (\$1.50) per day for each licensed inpatient
1203 acute care bed of the hospital.

1204 (b) A hospital is exempt from the assessment levied
1205 under this subsection if the hospital is operated under the
1206 direction and control of:

1207 (i) The United States Veterans Administration or
1208 other agency or department of the United States government;

1209 (ii) The University of Mississippi Medical Center;
1210 or

1211 (iii) A state agency or a state facility that
1212 either provides its own state match through intergovernmental
1213 transfer or certification of funds to the division.

1214 (4) Each health care facility that is subject to the
1215 provisions of this section shall keep and preserve such suitable
1216 books and records as may be necessary to determine the amount of
1217 assessment for which it is liable under this section. The books
1218 and records shall be kept and preserved for a period of not less
1219 than five (5) years, and those books and records shall be open for
1220 examination during business hours by the division, the State Tax
1221 Commission, the Office of the Attorney General and the State
1222 Department of Health.

1223 (5) The assessment levied under this section shall be
1224 collected by the division each month beginning on April 12, 2002.

1225 (6) All assessments collected under this section shall be
1226 deposited in the Medical Care Fund created by Section 43-13-143.

1227 (7) The assessment levied under this section shall be in
1228 addition to any other assessments, taxes or fees levied by law,
1229 and the assessment shall constitute a debt due the State of
1230 Mississippi from the time the assessment is due until it is paid.

1231 (8) (a) If a health care facility that is liable for
1232 payment of the assessment levied under this section does not pay



1233 the assessment when it is due, the division shall give written
1234 notice to the health care facility by certified or registered mail
1235 demanding payment of the assessment within ten (10) days from the
1236 date of delivery of the notice. If the health care facility
1237 fails or refuses to pay the assessment after receiving the notice
1238 and demand from the division, the division shall withhold from any
1239 Medicaid reimbursement payments that are due to the health care
1240 facility the amount of the unpaid assessment and a penalty of ten
1241 percent (10%) of the amount of the assessment, plus the legal rate
1242 of interest until the assessment is paid in full. If the health
1243 care facility does not participate in the Medicaid program, the
1244 division shall turn over to the Office of the Attorney General the
1245 collection of the unpaid assessment by civil action. In any such
1246 civil action, the Office of the Attorney General shall collect the
1247 amount of the unpaid assessment and a penalty of ten percent (10%)
1248 of the amount of the assessment, plus the legal rate of interest
1249 until the assessment is paid in full.

1250 (b) As an additional or alternative method for
1251 collecting unpaid assessments under this section, if a health care
1252 facility fails or refuses to pay the assessment after receiving
1253 notice and demand from the division, the division may file a
1254 notice of a tax lien with the circuit clerk of the county in which
1255 the health care facility is located, for the amount of the unpaid
1256 assessment and a penalty of ten percent (10%) of the amount of the
1257 assessment, plus the legal rate of interest until the assessment
1258 is paid in full. Immediately upon receipt of notice of the tax
1259 lien for the assessment, the circuit clerk shall enter the notice
1260 of the tax lien as a judgment upon the judgment roll and show in
1261 the appropriate columns the name of the health care facility as
1262 judgment debtor, the name of the division as judgment creditor,
1263 the amount of the unpaid assessment, and the date and time or
1264 enrollment. The judgment shall be valid as against mortgagees,
1265 pledgees, entrusters, purchasers, judgment creditors and other



1266 persons from the time of filing with the clerk. The amount of the
1267 judgment shall be a debt due the State of Mississippi and remain a
1268 lien upon the tangible property of the health care facility until
1269 the judgment is satisfied. The judgment shall be the equivalent
1270 of any enrolled judgment of a court of record and shall serve as
1271 authority for the issuance of writs of execution, writs of
1272 attachment or other remedial writs.

1273 **SECTION 6.** Section 41-7-191, Mississippi Code of 1972, is
1274 amended as follows:

1275 41-7-191. (1) No person shall engage in any of the
1276 following activities without obtaining the required certificate of
1277 need:

1278 (a) The construction, development or other
1279 establishment of a new health care facility;

1280 (b) The relocation of a health care facility or portion
1281 thereof, or major medical equipment, unless such relocation of a
1282 health care facility or portion thereof, or major medical
1283 equipment, which does not involve a capital expenditure by or on
1284 behalf of a health care facility, is within five thousand two
1285 hundred eighty (5,280) feet from the main entrance of the health
1286 care facility;

1287 (c) Any change in the existing bed complement of any
1288 health care facility through the addition or conversion of any
1289 beds or the alteration, modernizing or refurbishing of any unit or
1290 department in which the beds may be located;

1291 (d) Offering of the following health services if those
1292 services have not been provided on a regular basis by the proposed
1293 provider of such services within the period of twelve (12) months
1294 prior to the time such services would be offered:

1295 (i) Open heart surgery services;

1296 (ii) Cardiac catheterization services;

1297 (iii) Comprehensive inpatient rehabilitation

1298 services;



1299 (iv) Licensed psychiatric services;
1300 (v) Licensed chemical dependency services;
1301 (vi) Radiation therapy services;
1302 (vii) Diagnostic imaging services of an invasive
1303 nature, i.e. invasive digital angiography;
1304 (viii) Nursing home care as defined in
1305 subparagraphs (iv), (vi) and (viii) of Section 41-7-173(h);
1306 (ix) Home health services;
1307 (x) Swing-bed services;
1308 (xi) Ambulatory surgical services;
1309 (xii) Magnetic resonance imaging services;
1310 (xiii) Extracorporeal shock wave lithotripsy
1311 services;
1312 (xiv) Long-term care hospital services;
1313 (xv) Positron Emission Tomography (PET) services;
1314 (e) The relocation of one or more health services from
1315 one physical facility or site to another physical facility or
1316 site, unless such relocation, which does not involve a capital
1317 expenditure by or on behalf of a health care facility, (i) is to a
1318 physical facility or site within one thousand three hundred twenty
1319 (1,320) feet from the main entrance of the health care facility
1320 where the health care service is located, or (ii) is the result of
1321 an order of a court of appropriate jurisdiction or a result of
1322 pending litigation in such court, or by order of the State
1323 Department of Health, or by order of any other agency or legal
1324 entity of the state, the federal government, or any political
1325 subdivision of either, whose order is also approved by the State
1326 Department of Health;
1327 (f) The acquisition or otherwise control of any major
1328 medical equipment for the provision of medical services; provided,
1329 however, (i) the acquisition of any major medical equipment used
1330 only for research purposes, and (ii) the acquisition of major
1331 medical equipment to replace medical equipment for which a



1332 facility is already providing medical services and for which the
1333 State Department of Health has been notified before the date of
1334 such acquisition shall be exempt from this paragraph; an
1335 acquisition for less than fair market value must be reviewed, if
1336 the acquisition at fair market value would be subject to review;

1337 (g) Changes of ownership of existing health care
1338 facilities in which a notice of intent is not filed with the State
1339 Department of Health at least thirty (30) days prior to the date
1340 such change of ownership occurs, or a change in services or bed
1341 capacity as prescribed in paragraph (c) or (d) of this subsection
1342 as a result of the change of ownership; an acquisition for less
1343 than fair market value must be reviewed, if the acquisition at
1344 fair market value would be subject to review;

1345 (h) The change of ownership of any health care facility
1346 defined in subparagraphs (iv), (vi) and (viii) of Section
1347 41-7-173(h), in which a notice of intent as described in paragraph
1348 (g) has not been filed and if the Executive Director, Division of
1349 Medicaid, Office of the Governor, has not certified in writing
1350 that there will be no increase in allowable costs to Medicaid from
1351 revaluation of the assets or from increased interest and
1352 depreciation as a result of the proposed change of ownership;

1353 (i) Any activity described in paragraphs (a) through
1354 (h) if undertaken by any person if that same activity would
1355 require certificate of need approval if undertaken by a health
1356 care facility;

1357 (j) Any capital expenditure or deferred capital
1358 expenditure by or on behalf of a health care facility not covered
1359 by paragraphs (a) through (h);

1360 (k) The contracting of a health care facility as
1361 defined in subparagraphs (i) through (viii) of Section 41-7-173(h)
1362 to establish a home office, subunit, or branch office in the space
1363 operated as a health care facility through a formal arrangement



1364 with an existing health care facility as defined in subparagraph
1365 (ix) of Section 41-7-173(h).

1366 (2) From and after the effective date of Senate Bill No.
1367 2346, 2003 Regular Session), the State Department of Health shall
1368 not issue a certificate of need to any person for the new
1369 construction of, addition to, expansion of or conversion to any
1370 skilled or intermediate care nursing facility beds or services.
1371 Prior to the effective date of Senate Bill No. 2346, 2003 Regular
1372 Session), the State Department of Health shall not grant approval
1373 for or issue a certificate of need to any person proposing the new
1374 construction of, addition to, or expansion of any health care
1375 facility defined in subparagraphs (iv) (skilled nursing facility)
1376 and (vi) (intermediate care facility) of Section 41-7-173(h) or
1377 the conversion of vacant hospital beds to provide skilled or
1378 intermediate nursing home care, except as hereinafter authorized:

1379 (a) The department may issue a certificate of need to
1380 any person proposing the new construction of any health care
1381 facility defined in subparagraphs (iv) and (vi) of Section
1382 41-7-173(h) as part of a life care retirement facility, in any
1383 county bordering on the Gulf of Mexico in which is located a
1384 National Aeronautics and Space Administration facility, not to
1385 exceed forty (40) beds. From and after July 1, 1999, there shall
1386 be no prohibition or restrictions on participation in the Medicaid
1387 program (Section 43-13-101 et seq.) for the beds in the health
1388 care facility that were authorized under this paragraph (a).

1389 (b) The department may issue certificates of need in
1390 Harrison County to provide skilled nursing home care for
1391 Alzheimer's disease patients and other patients, not to exceed one
1392 hundred fifty (150) beds. From and after July 1, 1999, there
1393 shall be no prohibition or restrictions on participation in the
1394 Medicaid program (Section 43-13-101 et seq.) for the beds in the
1395 nursing facilities that were authorized under this paragraph (b).



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

1425 (d) The State Department of Health may issue a
1426 certificate of need to any hospital located in DeSoto County for
1427 the new construction of a skilled nursing facility, not to exceed
1428 one hundred twenty (120) beds, in DeSoto County. From and after



1429 July 1, 1999, there shall be no prohibition or restrictions on
1430 participation in the Medicaid program (Section 43-13-101 et seq.)
1431 for the beds in the nursing facility that were authorized under
1432 this paragraph (d).

1433 (e) The State Department of Health may issue a
1434 certificate of need for the construction of a nursing facility or
1435 the conversion of beds to nursing facility beds at a personal care
1436 facility for the elderly in Lowndes County that is owned and
1437 operated by a Mississippi nonprofit corporation, not to exceed
1438 sixty (60) beds. From and after July 1, 1999, there shall be no
1439 prohibition or restrictions on participation in the Medicaid
1440 program (Section 43-13-101 et seq.) for the beds in the nursing
1441 facility that were authorized under this paragraph (e).

1442 (f) The State Department of Health may issue a
1443 certificate of need for conversion of a county hospital facility
1444 in Itawamba County to a nursing facility, not to exceed sixty (60)
1445 beds, including any necessary construction, renovation or
1446 expansion. From and after July 1, 1999, there shall be no
1447 prohibition or restrictions on participation in the Medicaid
1448 program (Section 43-13-101 et seq.) for the beds in the nursing
1449 facility that were authorized under this paragraph (f).

1450 (g) The State Department of Health may issue a
1451 certificate of need for the construction or expansion of nursing
1452 facility beds or the conversion of other beds to nursing facility
1453 beds in either Hinds, Madison or Rankin County, not to exceed
1454 sixty (60) beds. From and after July 1, 1999, there shall be no
1455 prohibition or restrictions on participation in the Medicaid
1456 program (Section 43-13-101 et seq.) for the beds in the nursing
1457 facility that were authorized under this paragraph (g).

1458 (h) The State Department of Health may issue a
1459 certificate of need for the construction or expansion of nursing
1460 facility beds or the conversion of other beds to nursing facility
1461 beds in either Hancock, Harrison or Jackson County, not to exceed



1462 sixty (60) beds. From and after July 1, 1999, there shall be no
1463 prohibition or restrictions on participation in the Medicaid
1464 program (Section 43-13-101 et seq.) for the beds in the facility
1465 that were authorized under this paragraph (h).

1466 (i) The department may issue a certificate of need for
1467 the new construction of a skilled nursing facility in Leake
1468 County, provided that the recipient of the certificate of need
1469 agrees in writing that the skilled nursing facility will not at
1470 any time participate in the Medicaid program (Section 43-13-101 et
1471 seq.) or admit or keep any patients in the skilled nursing
1472 facility who are participating in the Medicaid program. This
1473 written agreement by the recipient of the certificate of need
1474 shall be fully binding on any subsequent owner of the skilled
1475 nursing facility, if the ownership of the facility is transferred
1476 at any time after the issuance of the certificate of need.
1477 Agreement that the skilled nursing facility will not participate
1478 in the Medicaid program shall be a condition of the issuance of a
1479 certificate of need to any person under this paragraph (i), and if
1480 such skilled nursing facility at any time after the issuance of
1481 the certificate of need, regardless of the ownership of the
1482 facility, participates in the Medicaid program or admits or keeps
1483 any patients in the facility who are participating in the Medicaid
1484 program, the State Department of Health shall revoke the
1485 certificate of need, if it is still outstanding, and shall deny or
1486 revoke the license of the skilled nursing facility, at the time
1487 that the department determines, after a hearing complying with due
1488 process, that the facility has failed to comply with any of the
1489 conditions upon which the certificate of need was issued, as
1490 provided in this paragraph and in the written agreement by the
1491 recipient of the certificate of need. The provision of Section
1492 43-7-193(1) regarding substantial compliance of the projection of
1493 need as reported in the current State Health Plan is waived for
1494 the purposes of this paragraph. The total number of nursing



1495 facility beds that may be authorized by any certificate of need
1496 issued under this paragraph (i) shall not exceed sixty (60) beds.
1497 If the skilled nursing facility authorized by the certificate of
1498 need issued under this paragraph is not constructed and fully
1499 operational within eighteen (18) months after July 1, 1994, the
1500 State Department of Health, after a hearing complying with due
1501 process, shall revoke the certificate of need, if it is still
1502 outstanding, and shall not issue a license for the skilled nursing
1503 facility at any time after the expiration of the eighteen-month
1504 period.

1505 (j) The department may issue certificates of need to
1506 allow any existing freestanding long-term care facility in
1507 Tishomingo County and Hancock County that on July 1, 1995, is
1508 licensed with fewer than sixty (60) beds. For the purposes of
1509 this paragraph (j), the provision of Section 41-7-193(1) requiring
1510 substantial compliance with the projection of need as reported in
1511 the current State Health Plan is waived. From and after July 1,
1512 1999, there shall be no prohibition or restrictions on
1513 participation in the Medicaid program (Section 43-13-101 et seq.)
1514 for the beds in the long-term care facilities that were authorized
1515 under this paragraph (j).

1516 (k) The department may issue a certificate of need for
1517 the construction of a nursing facility at a continuing care
1518 retirement community in Lowndes County. The total number of beds
1519 that may be authorized under the authority of this paragraph (k)
1520 shall not exceed sixty (60) beds. From and after July 1, 2001,
1521 the prohibition on the facility participating in the Medicaid
1522 program (Section 43-13-101 et seq.) that was a condition of
1523 issuance of the certificate of need under this paragraph (k) shall
1524 be revised as follows: The nursing facility may participate in
1525 the Medicaid program from and after July 1, 2001, if the owner of
1526 the facility on July 1, 2001, agrees in writing that no more than
1527 thirty (30) of the beds at the facility will be certified for



1528 participation in the Medicaid program, and that no claim will be
1529 submitted for Medicaid reimbursement for more than thirty (30)
1530 patients in the facility in any month or for any patient in the
1531 facility who is in a bed that is not Medicaid-certified. This
1532 written agreement by the owner of the facility shall be a
1533 condition of licensure of the facility, and the agreement shall be
1534 fully binding on any subsequent owner of the facility if the
1535 ownership of the facility is transferred at any time after July 1,
1536 2001. After this written agreement is executed, the Division of
1537 Medicaid and the State Department of Health shall not certify more
1538 than thirty (30) of the beds in the facility for participation in
1539 the Medicaid program. If the facility violates the terms of the
1540 written agreement by admitting or keeping in the facility on a
1541 regular or continuing basis more than thirty (30) patients who are
1542 participating in the Medicaid program, the State Department of
1543 Health shall revoke the license of the facility, at the time that
1544 the department determines, after a hearing complying with due
1545 process, that the facility has violated the written agreement.

1546 (1) Provided that funds are specifically appropriated
1547 therefor by the Legislature, the department may issue a
1548 certificate of need to a rehabilitation hospital in Hinds County
1549 for the construction of a sixty-bed long-term care nursing
1550 facility dedicated to the care and treatment of persons with
1551 severe disabilities including persons with spinal cord and
1552 closed-head injuries and ventilator-dependent patients. The
1553 provision of Section 41-7-193(1) regarding substantial compliance
1554 with projection of need as reported in the current State Health
1555 Plan is hereby waived for the purpose of this paragraph.

1556 (m) The State Department of Health may issue a
1557 certificate of need to a county-owned hospital in the Second
1558 Judicial District of Panola County for the conversion of not more
1559 than seventy-two (72) hospital beds to nursing facility beds,
1560 provided that the recipient of the certificate of need agrees in



1561 writing that none of the beds at the nursing facility will be
1562 certified for participation in the Medicaid program (Section
1563 43-13-101 et seq.), and that no claim will be submitted for
1564 Medicaid reimbursement in the nursing facility in any day or for
1565 any patient in the nursing facility. This written agreement by
1566 the recipient of the certificate of need shall be a condition of
1567 the issuance of the certificate of need under this paragraph, and
1568 the agreement shall be fully binding on any subsequent owner of
1569 the nursing facility if the ownership of the nursing facility is
1570 transferred at any time after the issuance of the certificate of
1571 need. After this written agreement is executed, the Division of
1572 Medicaid and the State Department of Health shall not certify any
1573 of the beds in the nursing facility for participation in the
1574 Medicaid program. If the nursing facility violates the terms of
1575 the written agreement by admitting or keeping in the nursing
1576 facility on a regular or continuing basis any patients who are
1577 participating in the Medicaid program, the State Department of
1578 Health shall revoke the license of the nursing facility, at the
1579 time that the department determines, after a hearing complying
1580 with due process, that the nursing facility has violated the
1581 condition upon which the certificate of need was issued, as
1582 provided in this paragraph and in the written agreement. If the
1583 certificate of need authorized under this paragraph is not issued
1584 within twelve (12) months after July 1, 2001, the department shall
1585 deny the application for the certificate of need and shall not
1586 issue the certificate of need at any time after the twelve-month
1587 period, unless the issuance is contested. If the certificate of
1588 need is issued and substantial construction of the nursing
1589 facility beds has not commenced within eighteen (18) months after
1590 July 1, 2001, the State Department of Health, after a hearing
1591 complying with due process, shall revoke the certificate of need
1592 if it is still outstanding, and the department shall not issue a
1593 license for the nursing facility at any time after the



1594 eighteen-month period. Provided, however, that if the issuance of
1595 the certificate of need is contested, the department shall require
1596 substantial construction of the nursing facility beds within six
1597 (6) months after final adjudication on the issuance of the
1598 certificate of need.

1599 (n) The department may issue a certificate of need for
1600 the new construction, addition or conversion of skilled nursing
1601 facility beds in Madison County, provided that the recipient of
1602 the certificate of need agrees in writing that the skilled nursing
1603 facility will not at any time participate in the Medicaid program
1604 (Section 43-13-101 et seq.) or admit or keep any patients in the
1605 skilled nursing facility who are participating in the Medicaid
1606 program. This written agreement by the recipient of the
1607 certificate of need shall be fully binding on any subsequent owner
1608 of the skilled nursing facility, if the ownership of the facility
1609 is transferred at any time after the issuance of the certificate
1610 of need. Agreement that the skilled nursing facility will not
1611 participate in the Medicaid program shall be a condition of the
1612 issuance of a certificate of need to any person under this
1613 paragraph (n), and if such skilled nursing facility at any time
1614 after the issuance of the certificate of need, regardless of the
1615 ownership of the facility, participates in the Medicaid program or
1616 admits or keeps any patients in the facility who are participating
1617 in the Medicaid program, the State Department of Health shall
1618 revoke the certificate of need, if it is still outstanding, and
1619 shall deny or revoke the license of the skilled nursing facility,
1620 at the time that the department determines, after a hearing
1621 complying with due process, that the facility has failed to comply
1622 with any of the conditions upon which the certificate of need was
1623 issued, as provided in this paragraph and in the written agreement
1624 by the recipient of the certificate of need. The total number of
1625 nursing facility beds that may be authorized by any certificate of
1626 need issued under this paragraph (n) shall not exceed sixty (60)



1627 beds. If the certificate of need authorized under this paragraph
1628 is not issued within twelve (12) months after July 1, 1998, the
1629 department shall deny the application for the certificate of need
1630 and shall not issue the certificate of need at any time after the
1631 twelve-month period, unless the issuance is contested. If the
1632 certificate of need is issued and substantial construction of the
1633 nursing facility beds has not commenced within eighteen (18)
1634 months after the effective date of July 1, 1998, the State
1635 Department of Health, after a hearing complying with due process,
1636 shall revoke the certificate of need if it is still outstanding,
1637 and the department shall not issue a license for the nursing
1638 facility at any time after the eighteen-month period. Provided,
1639 however, that if the issuance of the certificate of need is
1640 contested, the department shall require substantial construction
1641 of the nursing facility beds within six (6) months after final
1642 adjudication on the issuance of the certificate of need.

1643 (o) The department may issue a certificate of need for
1644 the new construction, addition or conversion of skilled nursing
1645 facility beds in Leake County, provided that the recipient of the
1646 certificate of need agrees in writing that the skilled nursing
1647 facility will not at any time participate in the Medicaid program
1648 (Section 43-13-101 et seq.) or admit or keep any patients in the
1649 skilled nursing facility who are participating in the Medicaid
1650 program. This written agreement by the recipient of the
1651 certificate of need shall be fully binding on any subsequent owner
1652 of the skilled nursing facility, if the ownership of the facility
1653 is transferred at any time after the issuance of the certificate
1654 of need. Agreement that the skilled nursing facility will not
1655 participate in the Medicaid program shall be a condition of the
1656 issuance of a certificate of need to any person under this
1657 paragraph (o), and if such skilled nursing facility at any time
1658 after the issuance of the certificate of need, regardless of the
1659 ownership of the facility, participates in the Medicaid program or



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

1687 (p) The department may issue a certificate of need for
1688 the construction of a municipally-owned nursing facility within
1689 the Town of Belmont in Tishomingo County, not to exceed sixty (60)
1690 beds, provided that the recipient of the certificate of need
1691 agrees in writing that the skilled nursing facility will not at
1692 any time participate in the Medicaid program (Section 43-13-101 et



1693 seq.) or admit or keep any patients in the skilled nursing
1694 facility who are participating in the Medicaid program. This
1695 written agreement by the recipient of the certificate of need
1696 shall be fully binding on any subsequent owner of the skilled
1697 nursing facility, if the ownership of the facility is transferred
1698 at any time after the issuance of the certificate of need.
1699 Agreement that the skilled nursing facility will not participate
1700 in the Medicaid program shall be a condition of the issuance of a
1701 certificate of need to any person under this paragraph (p), and if
1702 such skilled nursing facility at any time after the issuance of
1703 the certificate of need, regardless of the ownership of the
1704 facility, participates in the Medicaid program or admits or keeps
1705 any patients in the facility who are participating in the Medicaid
1706 program, the State Department of Health shall revoke the
1707 certificate of need, if it is still outstanding, and shall deny or
1708 revoke the license of the skilled nursing facility, at the time
1709 that the department determines, after a hearing complying with due
1710 process, that the facility has failed to comply with any of the
1711 conditions upon which the certificate of need was issued, as
1712 provided in this paragraph and in the written agreement by the
1713 recipient of the certificate of need. The provision of Section
1714 43-7-193(1) regarding substantial compliance of the projection of
1715 need as reported in the current State Health Plan is waived for
1716 the purposes of this paragraph. If the certificate of need
1717 authorized under this paragraph is not issued within twelve (12)
1718 months after July 1, 1998, the department shall deny the
1719 application for the certificate of need and shall not issue the
1720 certificate of need at any time after the twelve-month period,
1721 unless the issuance is contested. If the certificate of need is
1722 issued and substantial construction of the nursing facility beds
1723 has not commenced within eighteen (18) months after July 1, 1998,
1724 the State Department of Health, after a hearing complying with due
1725 process, shall revoke the certificate of need if it is still



1726 outstanding, and the department shall not issue a license for the
1727 nursing facility at any time after the eighteen-month period.
1728 Provided, however, that if the issuance of the certificate of need
1729 is contested, the department shall require substantial
1730 construction of the nursing facility beds within six (6) months
1731 after final adjudication on the issuance of the certificate of
1732 need.

1733 (q) (i) Beginning on July 1, 1999, the State
1734 Department of Health shall issue certificates of need during each
1735 of the next four (4) fiscal years for the construction or
1736 expansion of nursing facility beds or the conversion of other beds
1737 to nursing facility beds in each county in the state having a need
1738 for fifty (50) or more additional nursing facility beds, as shown
1739 in the fiscal year 1999 State Health Plan, in the manner provided
1740 in this paragraph (q). The total number of nursing facility beds
1741 that may be authorized by any certificate of need authorized under
1742 this paragraph (q) shall not exceed sixty (60) beds.

1743 (ii) Subject to the provisions of subparagraph
1744 (v), during each of the next four (4) fiscal years, the department
1745 shall issue six (6) certificates of need for new nursing facility
1746 beds, as follows: During fiscal years 2000, 2001 and 2002, one
1747 (1) certificate of need shall be issued for new nursing facility
1748 beds in the county in each of the four (4) Long-Term Care Planning
1749 Districts designated in the fiscal year 1999 State Health Plan
1750 that has the highest need in the district for those beds; and two
1751 (2) certificates of need shall be issued for new nursing facility
1752 beds in the two (2) counties from the state at large that have the
1753 highest need in the state for those beds, when considering the
1754 need on a statewide basis and without regard to the Long-Term Care
1755 Planning Districts in which the counties are located. During
1756 fiscal year 2003, one (1) certificate of need shall be issued for
1757 new nursing facility beds in any county having a need for fifty
1758 (50) or more additional nursing facility beds, as shown in the



1759 fiscal year 1999 State Health Plan, that has not received a
1760 certificate of need under this paragraph (q) during the three (3)
1761 previous fiscal years. During fiscal year 2000, in addition to
1762 the six (6) certificates of need authorized in this subparagraph,
1763 the department also shall issue a certificate of need for new
1764 nursing facility beds in Amite County and a certificate of need
1765 for new nursing facility beds in Carroll County.

1766 (iii) Subject to the provisions of subparagraph
1767 (v), the certificate of need issued under subparagraph (ii) for
1768 nursing facility beds in each Long-Term Care Planning District
1769 during each fiscal year shall first be available for nursing
1770 facility beds in the county in the district having the highest
1771 need for those beds, as shown in the fiscal year 1999 State Health
1772 Plan. If there are no applications for a certificate of need for
1773 nursing facility beds in the county having the highest need for
1774 those beds by the date specified by the department, then the
1775 certificate of need shall be available for nursing facility beds
1776 in other counties in the district in descending order of the need
1777 for those beds, from the county with the second highest need to
1778 the county with the lowest need, until an application is received
1779 for nursing facility beds in an eligible county in the district.

1780 (iv) Subject to the provisions of subparagraph
1781 (v), the certificate of need issued under subparagraph (ii) for
1782 nursing facility beds in the two (2) counties from the state at
1783 large during each fiscal year shall first be available for nursing
1784 facility beds in the two (2) counties that have the highest need
1785 in the state for those beds, as shown in the fiscal year 1999
1786 State Health Plan, when considering the need on a statewide basis
1787 and without regard to the Long-Term Care Planning Districts in
1788 which the counties are located. If there are no applications for
1789 a certificate of need for nursing facility beds in either of the
1790 two (2) counties having the highest need for those beds on a
1791 statewide basis by the date specified by the department, then the



1792 certificate of need shall be available for nursing facility beds
1793 in other counties from the state at large in descending order of
1794 the need for those beds on a statewide basis, from the county with
1795 the second highest need to the county with the lowest need, until
1796 an application is received for nursing facility beds in an
1797 eligible county from the state at large.

1798 (v) If a certificate of need is authorized to be
1799 issued under this paragraph (q) for nursing facility beds in a
1800 county on the basis of the need in the Long-Term Care Planning
1801 District during any fiscal year of the four-year period, a
1802 certificate of need shall not also be available under this
1803 paragraph (q) for additional nursing facility beds in that county
1804 on the basis of the need in the state at large, and that county
1805 shall be excluded in determining which counties have the highest
1806 need for nursing facility beds in the state at large for that
1807 fiscal year. After a certificate of need has been issued under
1808 this paragraph (q) for nursing facility beds in a county during
1809 any fiscal year of the four-year period, a certificate of need
1810 shall not be available again under this paragraph (q) for
1811 additional nursing facility beds in that county during the
1812 four-year period, and that county shall be excluded in determining
1813 which counties have the highest need for nursing facility beds in
1814 succeeding fiscal years.

1815 (vi) If more than one (1) application is made for
1816 a certificate of need for nursing home facility beds available
1817 under this paragraph (q), in Yalobusha, Newton or Tallahatchie
1818 County, and one (1) of the applicants is a county-owned hospital
1819 located in the county where the nursing facility beds are
1820 available, the department shall give priority to the county-owned
1821 hospital in granting the certificate of need if the following
1822 conditions are met:



1823 1. The county-owned hospital fully meets all
1824 applicable criteria and standards required to obtain a certificate
1825 of need for the nursing facility beds; and

1826 2. The county-owned hospital's qualifications
1827 for the certificate of need, as shown in its application and as
1828 determined by the department, are at least equal to the
1829 qualifications of the other applicants for the certificate of
1830 need.

1831 (r) (i) Beginning on July 1, 1999, the State
1832 Department of Health shall issue certificates of need during each
1833 of the next two (2) fiscal years for the construction or expansion
1834 of nursing facility beds or the conversion of other beds to
1835 nursing facility beds in each of the four (4) Long-Term Care
1836 Planning Districts designated in the fiscal year 1999 State Health
1837 Plan, to provide care exclusively to patients with Alzheimer's
1838 disease.

1839 (ii) Not more than twenty (20) beds may be
1840 authorized by any certificate of need issued under this paragraph
1841 (r), and not more than a total of sixty (60) beds may be
1842 authorized in any Long-Term Care Planning District by all
1843 certificates of need issued under this paragraph (r). However,
1844 the total number of beds that may be authorized by all
1845 certificates of need issued under this paragraph (r) during any
1846 fiscal year shall not exceed one hundred twenty (120) beds, and
1847 the total number of beds that may be authorized in any Long-Term
1848 Care Planning District during any fiscal year shall not exceed
1849 forty (40) beds. Of the certificates of need that are issued for
1850 each Long-Term Care Planning District during the next two (2)
1851 fiscal years, at least one (1) shall be issued for beds in the
1852 northern part of the district, at least one (1) shall be issued
1853 for beds in the central part of the district, and at least one (1)
1854 shall be issued for beds in the southern part of the district.



1855 (iii) The State Department of Health, in
1856 consultation with the Department of Mental Health and the Division
1857 of Medicaid, shall develop and prescribe the staffing levels,
1858 space requirements and other standards and requirements that must
1859 be met with regard to the nursing facility beds authorized under
1860 this paragraph (r) to provide care exclusively to patients with
1861 Alzheimer's disease.

1862 (3) The State Department of Health may grant approval for
1863 and issue certificates of need to any person proposing the new
1864 construction of, addition to, conversion of beds of or expansion
1865 of any health care facility defined in subparagraph (x)
1866 (psychiatric residential treatment facility) of Section
1867 41-7-173(h). The total number of beds which may be authorized by
1868 such certificates of need shall not exceed three hundred
1869 thirty-four (334) beds for the entire state.

1870 (a) Of the total number of beds authorized under this
1871 subsection, the department shall issue a certificate of need to a
1872 privately-owned psychiatric residential treatment facility in
1873 Simpson County for the conversion of sixteen (16) intermediate
1874 care facility for the mentally retarded (ICF-MR) beds to
1875 psychiatric residential treatment facility beds, provided that
1876 facility agrees in writing that the facility shall give priority
1877 for the use of those sixteen (16) beds to Mississippi residents
1878 who are presently being treated in out-of-state facilities.

1879 (b) Of the total number of beds authorized under this
1880 subsection, the department may issue a certificate or certificates
1881 of need for the construction or expansion of psychiatric
1882 residential treatment facility beds or the conversion of other
1883 beds to psychiatric residential treatment facility beds in Warren
1884 County, not to exceed sixty (60) psychiatric residential treatment
1885 facility beds, provided that the facility agrees in writing that
1886 no more than thirty (30) of the beds at the psychiatric
1887 residential treatment facility will be certified for participation



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

1916 The State Department of Health, on or before July 1, 2002,
1917 shall transfer the certificate of need authorized under the
1918 authority of this paragraph (b), or reissue the certificate of
1919 need if it has expired, to River Region Health System.



1920 (c) Of the total number of beds authorized under this
1921 subsection, the department shall issue a certificate of need to a
1922 hospital currently operating Medicaid-certified acute psychiatric
1923 beds for adolescents in DeSoto County, for the establishment of a
1924 forty-bed psychiatric residential treatment facility in DeSoto
1925 County, provided that the hospital agrees in writing (i) that the
1926 hospital shall give priority for the use of those forty (40) beds
1927 to Mississippi residents who are presently being treated in
1928 out-of-state facilities, and (ii) that no more than fifteen (15)
1929 of the beds at the psychiatric residential treatment facility will
1930 be certified for participation in the Medicaid program (Section
1931 43-13-101 et seq.), and that no claim will be submitted for
1932 Medicaid reimbursement for more than fifteen (15) patients in the
1933 psychiatric residential treatment facility in any day or for any
1934 patient in the psychiatric residential treatment facility who is
1935 in a bed that is not Medicaid-certified. This written agreement
1936 by the recipient of the certificate of need shall be a condition
1937 of the issuance of the certificate of need under this paragraph,
1938 and the agreement shall be fully binding on any subsequent owner
1939 of the psychiatric residential treatment facility if the ownership
1940 of the facility is transferred at any time after the issuance of
1941 the certificate of need. After this written agreement is
1942 executed, the Division of Medicaid and the State Department of
1943 Health shall not certify more than fifteen (15) of the beds in the
1944 psychiatric residential treatment facility for participation in
1945 the Medicaid program. If the psychiatric residential treatment
1946 facility violates the terms of the written agreement by admitting
1947 or keeping in the facility on a regular or continuing basis more
1948 than fifteen (15) patients who are participating in the Medicaid
1949 program, the State Department of Health shall revoke the license
1950 of the facility, at the time that the department determines, after
1951 a hearing complying with due process, that the facility has
1952 violated the condition upon which the certificate of need was



1953 issued, as provided in this paragraph and in the written
1954 agreement.

1955 (d) Of the total number of beds authorized under this
1956 subsection, the department may issue a certificate or certificates
1957 of need for the construction or expansion of psychiatric
1958 residential treatment facility beds or the conversion of other
1959 beds to psychiatric treatment facility beds, not to exceed thirty
1960 (30) psychiatric residential treatment facility beds, in either
1961 Alcorn, Tishomingo, Prentiss, Lee, Itawamba, Monroe, Chickasaw,
1962 Pontotoc, Calhoun, Lafayette, Union, Benton or Tippah County.

1963 (e) Of the total number of beds authorized under this
1964 subsection (3) the department shall issue a certificate of need to
1965 a privately-owned, nonprofit psychiatric residential treatment
1966 facility in Hinds County for an eight-bed expansion of the
1967 facility, provided that the facility agrees in writing that the
1968 facility shall give priority for the use of those eight (8) beds
1969 to Mississippi residents who are presently being treated in
1970 out-of-state facilities.

1971 (f) The department shall issue a certificate of need to
1972 a one-hundred-thirty-four-bed specialty hospital located on
1973 twenty-nine and forty-four one-hundredths (29.44) commercial acres
1974 at 5900 Highway 39 North in Meridian (Lauderdale County),
1975 Mississippi, for the addition, construction or expansion of
1976 child/adolescent psychiatric residential treatment facility beds
1977 in Lauderdale County. As a condition of issuance of the
1978 certificate of need under this paragraph, the facility shall give
1979 priority in admissions to the child/adolescent psychiatric
1980 residential treatment facility beds authorized under this
1981 paragraph to patients who otherwise would require out-of-state
1982 placement. The Division of Medicaid, in conjunction with the
1983 Department of Human Services, shall furnish the facility a list of
1984 all out-of-state patients on a quarterly basis. Furthermore,
1985 notice shall also be provided to the parent, custodial parent or



1986 guardian of each out-of-state patient notifying them of the
1987 priority status granted by this paragraph. For purposes of this
1988 paragraph, the provisions of Section 41-7-193(1) requiring
1989 substantial compliance with the projection of need as reported in
1990 the current State Health Plan are waived. The total number of
1991 child/adolescent psychiatric residential treatment facility beds
1992 that may be authorized under the authority of this paragraph shall
1993 be sixty (60) beds. There shall be no prohibition or restrictions
1994 on participation in the Medicaid program (Section 43-13-101 et
1995 seq.) for the person receiving the certificate of need authorized
1996 under this paragraph or for the beds converted pursuant to the
1997 authority of that certificate of need.

1998 (4) (a) From and after July 1, 1993, the department shall
1999 not issue a certificate of need to any person for the new
2000 construction of any hospital, psychiatric hospital or chemical
2001 dependency hospital that will contain any child/adolescent
2002 psychiatric or child/adolescent chemical dependency beds, or for
2003 the conversion of any other health care facility to a hospital,
2004 psychiatric hospital or chemical dependency hospital that will
2005 contain any child/adolescent psychiatric or child/adolescent
2006 chemical dependency beds, or for the addition of any
2007 child/adolescent psychiatric or child/adolescent chemical
2008 dependency beds in any hospital, psychiatric hospital or chemical
2009 dependency hospital, or for the conversion of any beds of another
2010 category in any hospital, psychiatric hospital or chemical
2011 dependency hospital to child/adolescent psychiatric or
2012 child/adolescent chemical dependency beds, except as hereinafter
2013 authorized:

2014 (i) The department may issue certificates of need
2015 to any person for any purpose described in this subsection,
2016 provided that the hospital, psychiatric hospital or chemical
2017 dependency hospital does not participate in the Medicaid program
2018 (Section 43-13-101 et seq.) at the time of the application for the



2019 certificate of need and the owner of the hospital, psychiatric
2020 hospital or chemical dependency hospital agrees in writing that
2021 the hospital, psychiatric hospital or chemical dependency hospital
2022 will not at any time participate in the Medicaid program or admit
2023 or keep any patients who are participating in the Medicaid program
2024 in the hospital, psychiatric hospital or chemical dependency
2025 hospital. This written agreement by the recipient of the
2026 certificate of need shall be fully binding on any subsequent owner
2027 of the hospital, psychiatric hospital or chemical dependency
2028 hospital, if the ownership of the facility is transferred at any
2029 time after the issuance of the certificate of need. Agreement
2030 that the hospital, psychiatric hospital or chemical dependency
2031 hospital will not participate in the Medicaid program shall be a
2032 condition of the issuance of a certificate of need to any person
2033 under this subparagraph (a)(i), and if such hospital, psychiatric
2034 hospital or chemical dependency hospital at any time after the
2035 issuance of the certificate of need, regardless of the ownership
2036 of the facility, participates in the Medicaid program or admits or
2037 keeps any patients in the hospital, psychiatric hospital or
2038 chemical dependency hospital who are participating in the Medicaid
2039 program, the State Department of Health shall revoke the
2040 certificate of need, if it is still outstanding, and shall deny or
2041 revoke the license of the hospital, psychiatric hospital or
2042 chemical dependency hospital, at the time that the department
2043 determines, after a hearing complying with due process, that the
2044 hospital, psychiatric hospital or chemical dependency hospital has
2045 failed to comply with any of the conditions upon which the
2046 certificate of need was issued, as provided in this subparagraph
2047 and in the written agreement by the recipient of the certificate
2048 of need.

2049 (ii) The department may issue a certificate of
2050 need for the conversion of existing beds in a county hospital in
2051 Choctaw County from acute care beds to child/adolescent chemical



2052 dependency beds. For purposes of this subparagraph, the
2053 provisions of Section 41-7-193(1) requiring substantial compliance
2054 with the projection of need as reported in the current State
2055 Health Plan is waived. The total number of beds that may be
2056 authorized under authority of this subparagraph shall not exceed
2057 twenty (20) beds. There shall be no prohibition or restrictions
2058 on participation in the Medicaid program (Section 43-13-101 et
2059 seq.) for the hospital receiving the certificate of need
2060 authorized under this subparagraph (a)(ii) or for the beds
2061 converted pursuant to the authority of that certificate of need.

2062 (iii) The department may issue a certificate or
2063 certificates of need for the construction or expansion of
2064 child/adolescent psychiatric beds or the conversion of other beds
2065 to child/adolescent psychiatric beds in Warren County. For
2066 purposes of this subparagraph, the provisions of Section
2067 41-7-193(1) requiring substantial compliance with the projection
2068 of need as reported in the current State Health Plan are waived.
2069 The total number of beds that may be authorized under the
2070 authority of this subparagraph shall not exceed twenty (20) beds.
2071 There shall be no prohibition or restrictions on participation in
2072 the Medicaid program (Section 43-13-101 et seq.) for the person
2073 receiving the certificate of need authorized under this
2074 subparagraph (a)(iii) or for the beds converted pursuant to the
2075 authority of that certificate of need.

2076 If by January 1, 2002, there has been no significant
2077 commencement of construction of the beds authorized under this
2078 subparagraph (a)(iii), or no significant action taken to convert
2079 existing beds to the beds authorized under this subparagraph, then
2080 the certificate of need that was previously issued under this
2081 subparagraph shall expire. If the previously issued certificate
2082 of need expires, the department may accept applications for
2083 issuance of another certificate of need for the beds authorized
2084 under this subparagraph, and may issue a certificate of need to



2085 authorize the construction, expansion or conversion of the beds
2086 authorized under this subparagraph.

2087 (iv) The department shall issue a certificate of
2088 need to the Region 7 Mental Health/Retardation Commission for the
2089 construction or expansion of child/adolescent psychiatric beds or
2090 the conversion of other beds to child/adolescent psychiatric beds
2091 in any of the counties served by the commission. For purposes of
2092 this subparagraph, the provisions of Section 41-7-193(1) requiring
2093 substantial compliance with the projection of need as reported in
2094 the current State Health Plan is waived. The total number of beds
2095 that may be authorized under the authority of this subparagraph
2096 shall not exceed twenty (20) beds. There shall be no prohibition
2097 or restrictions on participation in the Medicaid program (Section
2098 43-13-101 et seq.) for the person receiving the certificate of
2099 need authorized under this subparagraph (a)(iv) or for the beds
2100 converted pursuant to the authority of that certificate of need.

2101 (v) The department may issue a certificate of need
2102 to any county hospital located in Leflore County for the
2103 construction or expansion of adult psychiatric beds or the
2104 conversion of other beds to adult psychiatric beds, not to exceed
2105 twenty (20) beds, provided that the recipient of the certificate
2106 of need agrees in writing that the adult psychiatric beds will not
2107 at any time be certified for participation in the Medicaid program
2108 and that the hospital will not admit or keep any patients who are
2109 participating in the Medicaid program in any of such adult
2110 psychiatric beds. This written agreement by the recipient of the
2111 certificate of need shall be fully binding on any subsequent owner
2112 of the hospital if the ownership of the hospital is transferred at
2113 any time after the issuance of the certificate of need. Agreement
2114 that the adult psychiatric beds will not be certified for
2115 participation in the Medicaid program shall be a condition of the
2116 issuance of a certificate of need to any person under this
2117 subparagraph (a)(v), and if such hospital at any time after the



2118 issuance of the certificate of need, regardless of the ownership
2119 of the hospital, has any of such adult psychiatric beds certified
2120 for participation in the Medicaid program or admits or keeps any
2121 Medicaid patients in such adult psychiatric beds, the State
2122 Department of Health shall revoke the certificate of need, if it
2123 is still outstanding, and shall deny or revoke the license of the
2124 hospital at the time that the department determines, after a
2125 hearing complying with due process, that the hospital has failed
2126 to comply with any of the conditions upon which the certificate of
2127 need was issued, as provided in this subparagraph and in the
2128 written agreement by the recipient of the certificate of need.

2129 (vi) The department may issue a certificate or
2130 certificates of need for the expansion of child psychiatric beds
2131 or the conversion of other beds to child psychiatric beds at the
2132 University of Mississippi Medical Center. For purposes of this
2133 subparagraph (a)(vi), the provision of Section 41-7-193(1)
2134 requiring substantial compliance with the projection of need as
2135 reported in the current State Health Plan is waived. The total
2136 number of beds that may be authorized under the authority of this
2137 subparagraph (a)(vi) shall not exceed fifteen (15) beds. There
2138 shall be no prohibition or restrictions on participation in the
2139 Medicaid program (Section 43-13-101 et seq.) for the hospital
2140 receiving the certificate of need authorized under this
2141 subparagraph (a)(vi) or for the beds converted pursuant to the
2142 authority of that certificate of need.

2143 (b) From and after July 1, 1990, no hospital,
2144 psychiatric hospital or chemical dependency hospital shall be
2145 authorized to add any child/adolescent psychiatric or
2146 child/adolescent chemical dependency beds or convert any beds of
2147 another category to child/adolescent psychiatric or
2148 child/adolescent chemical dependency beds without a certificate of
2149 need under the authority of subsection (1)(c) of this section.



2150 (5) The department may issue a certificate of need to a
2151 county hospital in Winston County for the conversion of fifteen
2152 (15) acute care beds to geriatric psychiatric care beds.

2153 (6) The State Department of Health shall issue a certificate
2154 of need to a Mississippi corporation qualified to manage a
2155 long-term care hospital as defined in Section 41-7-173(h)(xii) in
2156 Harrison County, not to exceed eighty (80) beds, including any
2157 necessary renovation or construction required for licensure and
2158 certification, provided that the recipient of the certificate of
2159 need agrees in writing that the long-term care hospital will not
2160 at any time participate in the Medicaid program (Section 43-13-101
2161 et seq.) or admit or keep any patients in the long-term care
2162 hospital who are participating in the Medicaid program. This
2163 written agreement by the recipient of the certificate of need
2164 shall be fully binding on any subsequent owner of the long-term
2165 care hospital, if the ownership of the facility is transferred at
2166 any time after the issuance of the certificate of need. Agreement
2167 that the long-term care hospital will not participate in the
2168 Medicaid program shall be a condition of the issuance of a
2169 certificate of need to any person under this subsection (6), and
2170 if such long-term care hospital at any time after the issuance of
2171 the certificate of need, regardless of the ownership of the
2172 facility, participates in the Medicaid program or admits or keeps
2173 any patients in the facility who are participating in the Medicaid
2174 program, the State Department of Health shall revoke the
2175 certificate of need, if it is still outstanding, and shall deny or
2176 revoke the license of the long-term care hospital, at the time
2177 that the department determines, after a hearing complying with due
2178 process, that the facility has failed to comply with any of the
2179 conditions upon which the certificate of need was issued, as
2180 provided in this subsection and in the written agreement by the
2181 recipient of the certificate of need. For purposes of this
2182 subsection, the provision of Section 41-7-193(1) requiring



2183 substantial compliance with the projection of need as reported in
2184 the current State Health Plan is hereby waived.

2185 (7) The State Department of Health may issue a certificate
2186 of need to any hospital in the state to utilize a portion of its
2187 beds for the "swing-bed" concept. Any such hospital must be in
2188 conformance with the federal regulations regarding such swing-bed
2189 concept at the time it submits its application for a certificate
2190 of need to the State Department of Health, except that such
2191 hospital may have more licensed beds or a higher average daily
2192 census (ADC) than the maximum number specified in federal
2193 regulations for participation in the swing-bed program. Any
2194 hospital meeting all federal requirements for participation in the
2195 swing-bed program which receives such certificate of need shall
2196 render services provided under the swing-bed concept to any
2197 patient eligible for Medicare (Title XVIII of the Social Security
2198 Act) who is certified by a physician to be in need of such
2199 services, and no such hospital shall permit any patient who is
2200 eligible for both Medicaid and Medicare or eligible only for
2201 Medicaid to stay in the swing beds of the hospital for more than
2202 thirty (30) days per admission unless the hospital receives prior
2203 approval for such patient from the Division of Medicaid, Office of
2204 the Governor. Any hospital having more licensed beds or a higher
2205 average daily census (ADC) than the maximum number specified in
2206 federal regulations for participation in the swing-bed program
2207 which receives such certificate of need shall develop a procedure
2208 to insure that before a patient is allowed to stay in the swing
2209 beds of the hospital, there are no vacant nursing home beds
2210 available for that patient located within a fifty-mile radius of
2211 the hospital. When any such hospital has a patient staying in the
2212 swing beds of the hospital and the hospital receives notice from a
2213 nursing home located within such radius that there is a vacant bed
2214 available for that patient, the hospital shall transfer the
2215 patient to the nursing home within a reasonable time after receipt



2216 of the notice. Any hospital which is subject to the requirements
2217 of the two (2) preceding sentences of this subsection may be
2218 suspended from participation in the swing-bed program for a
2219 reasonable period of time by the State Department of Health if the
2220 department, after a hearing complying with due process, determines
2221 that the hospital has failed to comply with any of those
2222 requirements.

2223 (8) The Department of Health shall not grant approval for or
2224 issue a certificate of need to any person proposing the new
2225 construction of, addition to or expansion of a health care
2226 facility as defined in subparagraph (viii) of Section 41-7-173(h).

2227 (9) The Department of Health shall not grant approval for or
2228 issue a certificate of need to any person proposing the
2229 establishment of, or expansion of the currently approved territory
2230 of, or the contracting to establish a home office, subunit or
2231 branch office within the space operated as a health care facility
2232 as defined in Section 41-7-173(h)(i) through (viii) by a health
2233 care facility as defined in subparagraph (ix) of Section
2234 41-7-173(h).

2235 (10) Health care facilities owned and/or operated by the
2236 state or its agencies are exempt from the restraints in this
2237 section against issuance of a certificate of need if such addition
2238 or expansion consists of repairing or renovation necessary to
2239 comply with the state licensure law. This exception shall not
2240 apply to the new construction of any building by such state
2241 facility. This exception shall not apply to any health care
2242 facilities owned and/or operated by counties, municipalities,
2243 districts, unincorporated areas, other defined persons, or any
2244 combination thereof.

2245 (11) The new construction, renovation or expansion of or
2246 addition to any health care facility defined in subparagraph (ii)
2247 (psychiatric hospital), subparagraph (iv) (skilled nursing
2248 facility), subparagraph (vi) (intermediate care facility),



2249 subparagraph (viii) (intermediate care facility for the mentally
2250 retarded) and subparagraph (x) (psychiatric residential treatment
2251 facility) of Section 41-7-173(h) which is owned by the State of
2252 Mississippi and under the direction and control of the State
2253 Department of Mental Health, and the addition of new beds or the
2254 conversion of beds from one category to another in any such
2255 defined health care facility which is owned by the State of
2256 Mississippi and under the direction and control of the State
2257 Department of Mental Health, shall not require the issuance of a
2258 certificate of need under Section 41-7-171 et seq.,
2259 notwithstanding any provision in Section 41-7-171 et seq. to the
2260 contrary.

2261 (12) The new construction, renovation or expansion of or
2262 addition to any veterans homes or domiciliaries for eligible
2263 veterans of the State of Mississippi as authorized under Section
2264 35-1-19 shall not require the issuance of a certificate of need,
2265 notwithstanding any provision in Section 41-7-171 et seq. to the
2266 contrary.

2267 (13) The new construction of a nursing facility or nursing
2268 facility beds or the conversion of other beds to nursing facility
2269 beds shall not require the issuance of a certificate of need,
2270 notwithstanding any provision in Section 41-7-171 et seq. to the
2271 contrary, if the conditions of this subsection are met.

2272 (a) Before any construction or conversion may be
2273 undertaken without a certificate of need, the owner of the nursing
2274 facility, in the case of an existing facility, or the applicant to
2275 construct a nursing facility, in the case of new construction,
2276 first must file a written notice of intent and sign a written
2277 agreement with the State Department of Health that the entire
2278 nursing facility will not at any time participate in or have any
2279 beds certified for participation in the Medicaid program (Section
2280 43-13-101 et seq.), will not admit or keep any patients in the
2281 nursing facility who are participating in the Medicaid program,



2282 and will not submit any claim for Medicaid reimbursement for any
2283 patient in the facility. This written agreement by the owner or
2284 applicant shall be a condition of exercising the authority under
2285 this subsection without a certificate of need, and the agreement
2286 shall be fully binding on any subsequent owner of the nursing
2287 facility if the ownership of the facility is transferred at any
2288 time after the agreement is signed. After the written agreement
2289 is signed, the Division of Medicaid and the State Department of
2290 Health shall not certify any beds in the nursing facility for
2291 participation in the Medicaid program. If the nursing facility
2292 violates the terms of the written agreement by participating in
2293 the Medicaid program, having any beds certified for participation
2294 in the Medicaid program, admitting or keeping any patient in the
2295 facility who is participating in the Medicaid program, or
2296 submitting any claim for Medicaid reimbursement for any patient in
2297 the facility, the State Department of Health shall revoke the
2298 license of the nursing facility at the time that the department
2299 determines, after a hearing complying with due process, that the
2300 facility has violated the terms of the written agreement.

2301 (b) For the purposes of this subsection, participation
2302 in the Medicaid program by a nursing facility includes Medicaid
2303 reimbursement of coinsurance and deductibles for recipients who
2304 are qualified Medicare beneficiaries and/or those who are dually
2305 eligible. Any nursing facility exercising the authority under
2306 this subsection may not bill or submit a claim to the Division of
2307 Medicaid for services to qualified Medicare beneficiaries and/or
2308 those who are dually eligible.

2309 (c) The new construction of a nursing facility or
2310 nursing facility beds or the conversion of other beds to nursing
2311 facility beds described in this section must be either a part of a
2312 completely new continuing care retirement community, as described
2313 in the latest edition of the Mississippi State Health Plan, or an
2314 addition to existing personal care and independent living



2315 components, and so that the completed project will be a continuing
2316 care retirement community, containing (i) independent living
2317 accommodations, (ii) personal care beds, and (iii) the nursing
2318 home facility beds. The three (3) components must be located on a
2319 single site and be operated as one (1) inseparable facility. The
2320 nursing facility component must contain a minimum of thirty (30)
2321 beds. Any nursing facility beds authorized by this section will
2322 not be counted against the bed need set forth in the State Health
2323 Plan, as identified in Section 41-7-171 et seq.

2324 This subsection (13) shall stand repealed from and after July
2325 1, 2005.

2326 (14) The State Department of Health shall issue a
2327 certificate of need to any hospital which is currently licensed
2328 for two hundred fifty (250) or more acute care beds and is located
2329 in any general hospital service area not having a comprehensive
2330 cancer center, for the establishment and equipping of such a
2331 center which provides facilities and services for outpatient
2332 radiation oncology therapy, outpatient medical oncology therapy,
2333 and appropriate support services including the provision of
2334 radiation therapy services. The provision of Section 41-7-193(1)
2335 regarding substantial compliance with the projection of need as
2336 reported in the current State Health Plan is waived for the
2337 purpose of this subsection.

2338 (15) The State Department of Health may authorize the
2339 transfer of hospital beds, not to exceed sixty (60) beds, from the
2340 North Panola Community Hospital to the South Panola Community
2341 Hospital. The authorization for the transfer of those beds shall
2342 be exempt from the certificate of need review process.

2343 (16) Nothing in this section or in any other provision of
2344 Section 41-7-171 et seq. shall prevent any nursing facility from
2345 designating an appropriate number of existing beds in the facility
2346 as beds for providing care exclusively to patients with
2347 Alzheimer's disease.



2348 (17) Beginning July 1, 2003, and annually thereafter, the
2349 State Department of Health shall revise the State Health Plan to
2350 include home- and community-based services located in the health
2351 service districts as authorized alternatives to institutional
2352 nursing facility services in determining the need for such
2353 additional nursing facility beds.

2354 **SECTION 7.** This act shall take effect and be in force from
2355 and after its passage.

