

By: Representative Holland

To: Public Health and Welfare; Judiciary A

HOUSE BILL NO. 1201

1 AN ACT RELATING TO THE MISSISSIPPI MEDICAID LAW; TO AMEND  
2 SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO AUTHORIZE  
3 UNLIMITED DAY REIMBURSEMENT FOR DISPROPORTIONATE SHARE PROGRAM  
4 HOSPITALS FOR ELIGIBLE CHILDREN UNDER THE AGE OF SIX ONLY IF  
5 CERTIFIED AS MEDICALLY NECESSARY, TO AUTHORIZE THE DIVISION OF  
6 MEDICAID TO ESTABLISH A MEDICARE UPPER PAYMENT LIMITS PROGRAM FOR  
7 OUTPATIENT HOSPITAL SERVICES, TO AUTHORIZE THE DIVISION OF  
8 MEDICAID TO ESTABLISH A MEDICARE UPPER PAYMENT LIMITS PROGRAM FOR  
9 NURSING FACILITY SERVICES, TO REQUIRE THAT NURSING FACILITIES THAT  
10 PARTICIPATE IN THE MEDICAID PROGRAM ALSO BE CERTIFIED TO  
11 PARTICIPATE IN THE MEDICARE PROGRAM, TO DELETE SPECIFIC FEE  
12 INCREASES FOR PERIODIC SCREENING AND DIAGNOSTIC SERVICES, TO  
13 DELETE THE SPECIFIC DISPENSING FEE AUTHORIZED FOR PRESCRIPTION  
14 DRUG REIMBURSEMENT, TO DELETE CERTAIN CONDITIONS ON DRUG  
15 PRESCRIPTION REIMBURSEMENT, TO CLARIFY THE ESTIMATED ACQUISITION  
16 COST OF DRUGS, TO REVISE THE CONDITIONS FOR REIMBURSEMENT OF THE  
17 COST OF EYEGLASSES FOR RECIPIENTS, TO CLARIFY THE REQUIREMENT FOR  
18 DISPROPORTIONATE SHARE PROGRAM HOSPITALS TO PARTICIPATE IN THE  
19 FEDERAL INTERGOVERNMENTAL TRANSFER PROGRAM, TO CHANGE CERTAIN  
20 REFERENCES TO THE FEDERAL INDIVIDUALS WITH DISABILITIES EDUCATION  
21 ACT, TO AUTHORIZE MEDICAID REIMBURSEMENT TO RURAL HEALTH CENTERS  
22 FOR AMBULATORY SERVICES, TO AUTHORIZE MEDICAID REIMBURSEMENT TO  
23 CHIROPRACTORS FOR X-RAYS PERFORMED TO DOCUMENT CONDITIONS, AND TO  
24 AUTHORIZE THE DIVISION TO DEVELOP AND IMPLEMENT A DISEASE  
25 MANAGEMENT PROGRAM; TO AMEND SECTION 43-13-121, MISSISSIPPI CODE  
26 OF 1972, TO CLARIFY AND REVISE THE CONDITIONS FOR DENYING OR  
27 REVOKING PROVIDER ENROLLMENT IN THE MEDICAID PROGRAM; TO AMEND  
28 SECTION 43-13-123, MISSISSIPPI CODE OF 1972, TO CLARIFY THAT THE  
29 DIVISION SHALL OBTAIN SERVICES PURSUANT TO REGULATIONS OF THE  
30 PERSONAL SERVICE CONTRACT REVIEW BOARD; TO AMEND SECTION  
31 43-13-145, MISSISSIPPI CODE OF 1972, TO CLARIFY THAT THE MEDICAID  
32 ASSESSMENT IS TO BE ON ALL LICENSED OR CERTIFIED NURSING FACILITY  
33 BEDS IN THE STATE; TO AMEND SECTION 41-7-191, MISSISSIPPI CODE OF  
34 1972, TO DELETE THE REQUIREMENT THAT THE DIVISION OF MEDICAID  
35 FURNISH A CERTAIN RESIDENTIAL FACILITY THE NAMES AND MEDICAL  
36 INFORMATION ABOUT RECIPIENTS RECEIVING SERVICES OUT OF STATE; TO  
37 CODIFY NEW SECTION 11-11-8, MISSISSIPPI CODE OF 1972, TO SPECIFY  
38 THE VENUE FOR ACTIONS AGAINST NURSING HOMES FOR INJURY OR DAMAGES  
39 OR WRONGFUL DEATH; TO AMEND SECTION 15-1-36, MISSISSIPPI CODE OF  
40 1972, TO INCLUDE NURSING HOMES AND OTHER LONG-TERM CARE FACILITIES  
41 TO THE STATUTE OF LIMITATIONS APPLICABLE TO TORT ACTIONS FOR  
42 INJURIES OR WRONGFUL DEATH ARISING FROM MEDICAL OR OTHER  
43 PROFESSIONAL SERVICES; TO AMEND SECTION 43-11-7, MISSISSIPPI CODE  
44 OF 1972, TO PROVIDE THAT ANY PERSON MAY APPLY FOR A LICENSE FOR A  
45 NURSING HOME; TO AMEND SECTION 43-11-13, MISSISSIPPI CODE OF 1972,  
46 TO PROVIDE THAT RULES, REGULATIONS OR STANDARDS PROMULGATED BY THE  
47 STATE DEPARTMENT OF HEALTH UNDER THE LICENSING LAW SHALL NOT BE  
48 CONSTRUED AS ESTABLISHING A MEDICAL STANDARD OF CARE; TO AMEND  
49 SECTION 43-11-19, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT  
50 INFORMATION RECEIVED OR CAUSED TO BE MAINTAINED OR COLLECTED BY  
51 THE STATE DEPARTMENT OF HEALTH THROUGH FILED REPORTS OR INSPECTION  
52 UNDER THE NURSING HOME LICENSURE LAW SHALL NOT BE DISCLOSED BY ANY



53 PERSON OR PARTY, EXCEPT IN A PROCEEDING INVOLVING THE QUESTIONS OF  
54 LICENSURE; TO AMEND SECTION 41-63-21, MISSISSIPPI CODE OF 1972, TO  
55 DELETE CERTAIN REPORTS, RECORDS AND CORRESPONDENCE THAT ARE  
56 PREPARED BY THE STATE DEPARTMENT OF HEALTH FROM THE DEFINITION OF  
57 "ACCREDITATION AND QUALITY ASSURANCE MATERIALS"; TO AMEND SECTION  
58 43-7-53, MISSISSIPPI CODE OF 1972, TO REQUIRE THAT THE  
59 QUALIFICATIONS FOR STATE AND COMMUNITY LONG-TERM CARE FACILITIES  
60 OMBUDSMEN SHALL INCLUDE TRAINING AND EXPERIENCE WITH LONG-TERM  
61 CARE FACILITIES; TO AMEND SECTION 43-7-61, MISSISSIPPI CODE OF  
62 1972, TO REQUIRE LONG-TERM CARE FACILITIES OMBUDSMEN TO  
63 PARTICIPATE IN ONGOING TRAINING PROGRAMS RELATED TO THEIR DUTIES  
64 AND RESPONSIBILITIES; AND FOR RELATED PURPOSES.

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

66 **SECTION 1.** Section 43-13-117, Mississippi Code of 1972, is  
67 amended as follows:

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

75 (1) Inpatient hospital services.

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

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

89 (c) Hospitals will receive an additional payment  
90 for the implantable programmable baclofen drug pump used to treat  
91 spasticity which is implanted on an inpatient basis. The payment



92 pursuant to written invoice will be in addition to the facility's  
93 per diem reimbursement and will represent a reduction of costs on  
94 the facility's annual cost report, and shall not exceed Ten  
95 Thousand Dollars (\$10,000.00) per year per recipient. This  
96 paragraph (c) shall stand repealed on July 1, 2005.

97 (2) Outpatient hospital services.

98 (a) Provided that where the same services are  
99 reimbursed as clinic services, the division may revise the rate or  
100 methodology of outpatient reimbursement to maintain consistency,  
101 efficiency, economy and quality of care. The division shall  
102 develop a Medicaid-specific cost-to-charge ratio calculation from  
103 data provided by hospitals to determine an allowable rate payment  
104 for outpatient hospital services, and shall submit a report  
105 thereon to the Medical Advisory Committee on or before December 1,  
106 1999. The committee shall make a recommendation on the specific  
107 cost-to-charge reimbursement method for outpatient hospital  
108 services to the 2000 Regular Session of the Legislature.

109 (b) In addition to reimbursement methodology for  
110 outpatient hospital services, the division may establish a  
111 Medicare upper payment limits program for outpatient hospital  
112 services in accordance with applicable federal law and  
113 regulations. The division may assess each hospital for the sole  
114 purpose of financing the state portion of the Medicare upper  
115 payment limits program for outpatient hospital services based on  
116 appropriate methodology consistent with federal law and  
117 regulations. This assessment will remain in effect as long as the  
118 state participates in a Medicare upper payment limits program for  
119 outpatient hospital services.

120 (3) Laboratory and x-ray services.

121 (4) Nursing facility services.

122 (a) The division shall make full payment to  
123 nursing facilities for each day, not exceeding fifty-two (52) days  
124 per year, that a patient is absent from the facility on home



125 leave. Payment may be made for the following home leave days in  
126 addition to the fifty-two-day limitation: Christmas, the day  
127 before Christmas, the day after Christmas, Thanksgiving, the day  
128 before Thanksgiving and the day after Thanksgiving.

129 (b) From and after July 1, 1997, the division  
130 shall implement the integrated case-mix payment and quality  
131 monitoring system, which includes the fair rental system for  
132 property costs and in which recapture of depreciation is  
133 eliminated. The division may reduce the payment for hospital  
134 leave and therapeutic home leave days to the lower of the case-mix  
135 category as computed for the resident on leave using the  
136 assessment being utilized for payment at that point in time, or a  
137 case-mix score of 1.000 for nursing facilities, and shall compute  
138 case-mix scores of residents so that only services provided at the  
139 nursing facility are considered in calculating a facility's per  
140 diem.

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

144 (d) When a facility of a category that does not  
145 require a certificate of need for construction and that could not  
146 be eligible for Medicaid reimbursement is constructed to nursing  
147 facility specifications for licensure and certification, and the  
148 facility is subsequently converted to a nursing facility pursuant  
149 to a certificate of need that authorizes conversion only and the  
150 applicant for the certificate of need was assessed an application  
151 review fee based on capital expenditures incurred in constructing  
152 the facility, the division shall allow reimbursement for capital  
153 expenditures necessary for construction of the facility that were  
154 incurred within the twenty-four (24) consecutive calendar months  
155 immediately preceding the date that the certificate of need  
156 authorizing such conversion was issued, to the same extent that  
157 reimbursement would be allowed for construction of a new nursing



158 facility pursuant to a certificate of need that authorizes such  
159 construction. The reimbursement authorized in this subparagraph  
160 (d) may be made only to facilities the construction of which was  
161 completed after June 30, 1989. Before the division shall be  
162 authorized to make the reimbursement authorized in this  
163 subparagraph (d), the division first must have received approval  
164 from the Health Care Financing Administration of the United States  
165 Department of Health and Human Services of the change in the state  
166 Medicaid plan providing for such reimbursement.

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

180 (f) The Division of Medicaid shall develop and  
181 implement a referral process for long-term care alternatives for  
182 Medicaid beneficiaries and applicants. No Medicaid beneficiary  
183 shall be admitted to a Medicaid-certified nursing facility unless  
184 a licensed physician certifies that nursing facility care is  
185 appropriate for that person on a standardized form to be prepared  
186 and provided to nursing facilities by the Division of Medicaid.  
187 The physician shall forward a copy of that certification to the  
188 Division of Medicaid within twenty-four (24) hours after it is  
189 signed by the physician. Any physician who fails to forward the  
190 certification to the Division of Medicaid within the time period



191 specified in this paragraph shall be ineligible for Medicaid  
192 reimbursement for any physician's services performed for the  
193 applicant. The Division of Medicaid shall determine, through an  
194 assessment of the applicant conducted within two (2) business days  
195 after receipt of the physician's certification, whether the  
196 applicant also could live appropriately and cost-effectively at  
197 home or in some other community-based setting if home- or  
198 community-based services were available to the applicant. The  
199 time limitation prescribed in this paragraph shall be waived in  
200 cases of emergency. If the Division of Medicaid determines that a  
201 home- or other community-based setting is appropriate and  
202 cost-effective, the division shall:

203 (i) Advise the applicant or the applicant's  
204 legal representative that a home- or other community-based setting  
205 is appropriate;

206 (ii) Provide a proposed care plan and inform  
207 the applicant or the applicant's legal representative regarding  
208 the degree to which the services in the care plan are available in  
209 a home- or in other community-based setting rather than nursing  
210 facility care; and

211 (iii) Explain that such plan and services are  
212 available only if the applicant or the applicant's legal  
213 representative chooses a home- or community-based alternative to  
214 nursing facility care, and that the applicant is free to choose  
215 nursing facility care.

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

221 Placement in a nursing facility may not be denied by the  
222 division if home- or community-based services that would be more  
223 appropriate than nursing facility care are not actually available,



224 or if the applicant chooses not to receive the appropriate home-  
225 or community-based services.

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

230 The division shall make full payment for long-term care  
231 alternative services.

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

236 (g) In addition to reimbursement methodology for  
237 nursing facility services, the division may establish a Medicare  
238 upper payment limits program for nursing facility services in  
239 accordance with applicable federal law and regulations. The  
240 division may assess each nursing facility for the sole purpose of  
241 financing the state portion of the Medicare upper payment limits  
242 program for nursing facility services based on appropriate  
243 methodology consistent with federal law and regulations. This  
244 assessment will remain in effect as long as the state participates  
245 in a Medicare upper payment limits program for nursing facility  
246 services.

247 (h) Effective July 1, 2003, all Title XIX nursing  
248 facilities must be Title XVIII certified in order to participate  
249 in the Medicaid program.

250 (5) Periodic screening and diagnostic services for  
251 individuals under age twenty-one (21) years as are needed to  
252 identify physical and mental defects and to provide health care  
253 treatment and other measures designed to correct or ameliorate  
254 defects and physical and mental illness and conditions discovered  
255 by the screening services regardless of whether these services are  
256 included in the state plan. The division may include in its



257 periodic screening and diagnostic program those discretionary  
258 services authorized under the federal regulations adopted to  
259 implement Title XIX of the federal Social Security Act, as  
260 amended. The division, in obtaining physical therapy services,  
261 occupational therapy services, and services for individuals with  
262 speech, hearing and language disorders, may enter into a  
263 cooperative agreement with the State Department of Education for  
264 the provision of such services to handicapped students by public  
265 school districts using state funds which are provided from the  
266 appropriation to the Department of Education to obtain federal  
267 matching funds through the division. The division, in obtaining  
268 medical and psychological evaluations for children in the custody  
269 of the State Department of Human Services may enter into a  
270 cooperative agreement with the State Department of Human Services  
271 for the provision of such services using state funds which are  
272 provided from the appropriation to the Department of Human  
273 Services to obtain federal matching funds through the division.

274 \* \* \*

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





289 (7) (a) Home health services for eligible persons, not  
290 to exceed in cost the prevailing cost of nursing facility  
291 services, not to exceed sixty (60) visits per year. All home  
292 health visits must be precertified as required by the division.

293 (b) Repealed.

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

305 (9) Legend and other drugs as may be determined by the  
306 division. The division may implement a program of prior approval  
307 for drugs to the extent permitted by law. Payment by the division  
308 for covered multiple source drugs shall be limited to the lower of  
309 the upper limits established and published by the Health Care  
310 Financing Administration (HCFA) plus a dispensing fee as  
311 determined by the division, or the estimated acquisition cost  
312 (EAC) \* \* \* plus a dispensing fee as determined by the division,  
313 or the providers' usual and customary charge to the general  
314 public. The division shall allow ten (10) prescriptions per  
315 month \* \* \*.

316 Payment for other covered drugs, other than multiple source  
317 drugs with HCFA upper limits, shall not exceed the lower of the  
318 estimated acquisition cost as determined by the division plus a  
319 dispensing fee as determined by the division, or the providers'  
320 usual and customary charge to the general public.



321 Payment for nonlegend or over-the-counter drugs covered on  
322 the division's formulary shall be reimbursed at the lower of the  
323 division's estimated shelf price or the providers' usual and  
324 customary charge to the general public. No dispensing fee shall  
325 be paid.

326 The division shall develop and implement a program of payment  
327 for additional pharmacist services, with payment to be based on  
328 demonstrated savings \* \* \*.

329 As used in this paragraph (9), "estimated acquisition cost"  
330 means the division's best estimate of the actual purchase price  
331 currently paid by a provider for drugs. Product selection shall  
332 be made in compliance with existing state law; however, the  
333 division may reimburse as if the prescription had been filled  
334 under the generic name. The division may provide otherwise in the  
335 case of specified drugs when the consensus of competent medical  
336 advice is that trademarked drugs are substantially more effective.

337 (10) Dental care that is an adjunct to treatment of an  
338 acute medical or surgical condition; services of oral surgeons and  
339 dentists in connection with surgery related to the jaw or any  
340 structure contiguous to the jaw or the reduction of any fracture  
341 of the jaw or any facial bone; and emergency dental extractions  
342 and treatment related thereto. On July 1, 1999, all fees for  
343 dental care and surgery under authority of this paragraph (10)  
344 shall be increased to one hundred sixty percent (160%) of the  
345 amount of the reimbursement rate that was in effect on June 30,  
346 1999. It is the intent of the Legislature to encourage more  
347 dentists to participate in the Medicaid program.

348 (11) Eyeglasses for all Medicaid beneficiaries who have  
349 (a) had \* \* \* surgery on the eyeball or ocular muscle which  
350 results in a vision change for which eyeglasses or a change in  
351 eyeglasses is medically indicated within six (6) months of the  
352 surgery and is in accordance with policies established by the  
353 division, or (b) one (1) pair every three (3) years and in



354 accordance with policies established by the division. In either  
355 instance, the eyeglasses must be prescribed by a physician skilled  
356 in the diseases of the eye or an optometrist, whichever the  
357 beneficiary may select.

358 (12) Intermediate care facility services.

359 (a) The division shall make full payment to all  
360 intermediate care facilities for the mentally retarded for each  
361 day, not exceeding eighty-four (84) days per year, that a patient  
362 is absent from the facility on home leave. Payment may be made  
363 for the following home leave days in addition to the  
364 eighty-four-day limitation: Christmas, the day before Christmas,  
365 the day after Christmas, Thanksgiving, the day before Thanksgiving  
366 and the day after Thanksgiving.

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

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

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



387 January 1, 1994. All fees for physicians' services that are  
388 covered by both Medicare and Medicaid shall be reimbursed at ten  
389 percent (10%) of the adjusted Medicare payment established on  
390 January 1, 1999, and as adjusted each January thereafter, under  
391 Medicare (Title XVIII of the Social Security Act, as amended), and  
392 which shall in no event be less than seventy percent (70%) of the  
393 adjusted Medicare payment established on January 1, 1994. On July  
394 1, 1999, all fees for dentists' services reimbursed under  
395 authority of this paragraph (14) shall be increased to one hundred  
396 sixty percent (160%) of the amount of the reimbursement rate that  
397 was in effect on June 30, 1999.

398 (15) Home- and community-based services, as provided  
399 under Title XIX of the federal Social Security Act, as amended,  
400 under waivers, subject to the availability of funds specifically  
401 appropriated therefor by the Legislature. Payment for such  
402 services shall be limited to individuals who would be eligible for  
403 and would otherwise require the level of care provided in a  
404 nursing facility. The home- and community-based services  
405 authorized under this paragraph shall be expanded over a five-year  
406 period beginning July 1, 1999. The division shall certify case  
407 management agencies to provide case management services and  
408 provide for home- and community-based services for eligible  
409 individuals under this paragraph. The home- and community-based  
410 services under this paragraph and the activities performed by  
411 certified case management agencies under this paragraph shall be  
412 funded using state funds that are provided from the appropriation  
413 to the Division of Medicaid and used to match federal funds.

414 (16) Mental health services. Approved therapeutic and  
415 case management services provided by (a) an approved regional  
416 mental health/retardation center established under Sections  
417 41-19-31 through 41-19-39, or by another community mental health  
418 service provider meeting the requirements of the Department of  
419 Mental Health to be an approved mental health/retardation center



420 if determined necessary by the Department of Mental Health, using  
421 state funds which are provided from the appropriation to the State  
422 Department of Mental Health and used to match federal funds under  
423 a cooperative agreement between the division and the department,  
424 or (b) a facility which is certified by the State Department of  
425 Mental Health to provide therapeutic and case management services,  
426 to be reimbursed on a fee for service basis. Any such services  
427 provided by a facility described in paragraph (b) must have the  
428 prior approval of the division to be reimbursable under this  
429 section. After June 30, 1997, mental health services provided by  
430 regional mental health/retardation centers established under  
431 Sections 41-19-31 through 41-19-39, or by hospitals as defined in  
432 Section 41-9-3(a) and/or their subsidiaries and divisions, or by  
433 psychiatric residential treatment facilities as defined in Section  
434 43-11-1, or by another community mental health service provider  
435 meeting the requirements of the Department of Mental Health to be  
436 an approved mental health/retardation center if determined  
437 necessary by the Department of Mental Health, shall not be  
438 included in or provided under any capitated managed care pilot  
439 program provided for under paragraph (24) of this section.

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

446 (18) (a) Notwithstanding any other provision of this  
447 section to the contrary, the division shall make additional  
448 reimbursement to hospitals which serve a disproportionate share of  
449 low-income patients and which meet the federal requirements for  
450 such payments as provided in Section 1923 of the federal Social  
451 Security Act and any applicable regulations. However, from and  
452 after January 1, 1999, no public hospital shall participate in the



453 Medicaid disproportionate share program unless the public hospital  
454 participates in an intergovernmental transfer program as provided  
455 in Section 1903 of the federal Social Security Act and any  
456 applicable regulations. Administration and support for  
457 participating hospitals shall be provided by the Mississippi  
458 Hospital Association.

459 (b) The division shall establish a Medicare Upper  
460 Payment Limits Program as defined in Section 1902 (a) (30) of the  
461 federal Social Security Act and any applicable federal  
462 regulations. The division shall assess each hospital for the sole  
463 purpose of financing the state portion of the Medicare Upper  
464 Payment Limits Program. This assessment shall be based on  
465 Medicaid utilization, or other appropriate method consistent with  
466 federal regulations, and will remain in effect as long as the  
467 state participates in the Medicare Upper Payment Limits Program.  
468 The division shall make additional reimbursement to hospitals for  
469 the Medicare Upper Payment Limits as defined in Section 1902 (a)  
470 (30) of the federal Social Security Act and any applicable federal  
471 regulations. This paragraph (b) shall stand repealed from and  
472 after July 1, 2005.

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

478 (19) (a) Perinatal risk management services. The  
479 division shall promulgate regulations to be effective from and  
480 after October 1, 1988, to establish a comprehensive perinatal  
481 system for risk assessment of all pregnant and infant Medicaid  
482 recipients and for management, education and follow-up for those  
483 who are determined to be at risk. Services to be performed  
484 include case management, nutrition assessment/counseling,  
485 psychosocial assessment/counseling and health education. The



486 division shall set reimbursement rates for providers in  
487 conjunction with the State Department of Health.

488 (b) Early intervention system services. The  
489 division shall cooperate with the State Department of Health,  
490 acting as lead agency, in the development and implementation of a  
491 statewide system of delivery of early intervention services,  
492 pursuant to Part C of the Individuals with Disabilities Education  
493 Act (IDEA). The State Department of Health shall certify annually  
494 in writing to the director of the division the dollar amount of  
495 state early intervention funds available which shall be utilized  
496 as a certified match for Medicaid matching funds. Those funds  
497 then shall be used to provide expanded targeted case management  
498 services for Medicaid eligible children with special needs who are  
499 eligible for the state's early intervention system.

500 Qualifications for persons providing service coordination shall be  
501 determined by the State Department of Health and the Division of  
502 Medicaid.

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

513 (21) Nurse practitioner services. Services furnished  
514 by a registered nurse who is licensed and certified by the  
515 Mississippi Board of Nursing as a nurse practitioner including,  
516 but not limited to, nurse anesthetists, nurse midwives, family  
517 nurse practitioners, family planning nurse practitioners,  
518 pediatric nurse practitioners, obstetrics-gynecology nurse



519 practitioners and neonatal nurse practitioners, under regulations  
520 adopted by the division. Reimbursement for such services shall  
521 not exceed ninety percent (90%) of the reimbursement rate for  
522 comparable services rendered by a physician.

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

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

540           (24) Managed care services in a program to be developed  
541 by the division by a public or private provider. If managed care  
542 services are provided by the division to Medicaid recipients, and  
543 those managed care services are operated, managed and controlled  
544 by and under the authority of the division, the division shall be  
545 responsible for educating the Medicaid recipients who are  
546 participants in the managed care program regarding the manner in  
547 which the participants should seek health care under the program.  
548 Notwithstanding any other provision in this article to the  
549 contrary, the division shall establish rates of reimbursement to  
550 providers rendering care and services authorized under this  
551 paragraph (24), and may revise such rates of reimbursement without





552 amendment to this section by the Legislature for the purpose of  
553 achieving effective and accessible health services, and for  
554 responsible containment of costs.

555 (25) Birthing center services.

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

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

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

574 (29) The Division of Medicaid may apply for a waiver  
575 from the Department of Health and Human Services for home- and  
576 community-based services for developmentally disabled people using  
577 state funds which are provided from the appropriation to the State  
578 Department of Mental Health and used to match federal funds under  
579 a cooperative agreement between the division and the department,  
580 provided that funds for these services are specifically  
581 appropriated to the Department of Mental Health.

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



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

590           (32) Care and services provided in Christian Science  
591 Sanatoria operated by or listed and certified by The First Church  
592 of Christ Scientist, Boston, Massachusetts, rendered in connection  
593 with treatment by prayer or spiritual means to the extent that  
594 such services are subject to reimbursement under Section 1903 of  
595 the Social Security Act.

596           (33) Podiatrist services.

597           (34) The division shall make application to the United  
598 States Health Care Financing Administration for a waiver to  
599 develop a program of services to personal care and assisted living  
600 homes in Mississippi. This waiver shall be completed by December  
601 1, 1999.

602           (35) Services and activities authorized in Sections  
603 43-27-101 and 43-27-103, using state funds that are provided from  
604 the appropriation to the State Department of Human Services and  
605 used to match federal funds under a cooperative agreement between  
606 the division and the department.

607           (36) Nonemergency transportation services for  
608 Medicaid-eligible persons, to be provided by the Division of  
609 Medicaid. The division may contract with additional entities to  
610 administer nonemergency transportation services as it deems  
611 necessary. All providers shall have a valid driver's license,  
612 vehicle inspection sticker, valid vehicle license tags and a  
613 standard liability insurance policy covering the vehicle.

614           (37) [Deleted]

615           (38) Chiropractic services: a chiropractor's manual  
616 manipulation of the spine to correct a subluxation, if x-ray



617 demonstrates that a subluxation exists and if the subluxation has  
618 resulted in a neuromusculoskeletal condition for which  
619 manipulation is appropriate treatment, and related spinal x-rays  
620 performed to document these conditions. Reimbursement for  
621 chiropractic services shall not exceed Seven Hundred Dollars  
622 (\$700.00) per year per beneficiary.

623 (39) Dually eligible Medicare/Medicaid beneficiaries.  
624 The division shall pay the Medicare deductible and ten percent  
625 (10%) coinsurance amounts for services available under Medicare  
626 for the duration and scope of services otherwise available under  
627 the Medicaid program.

628 (40) [Deleted]

629 (41) Services provided by the State Department of  
630 Rehabilitation Services for the care and rehabilitation of persons  
631 with spinal cord injuries or traumatic brain injuries, as allowed  
632 under waivers from the United States Department of Health and  
633 Human Services, using up to seventy-five percent (75%) of the  
634 funds that are appropriated to the Department of Rehabilitation  
635 Services from the Spinal Cord and Head Injury Trust Fund  
636 established under Section 37-33-261 and used to match federal  
637 funds under a cooperative agreement between the division and the  
638 department.

639 (42) Notwithstanding any other provision in this  
640 article to the contrary, the division is hereby authorized to  
641 develop a population health management program for women and  
642 children health services through the age of two (2). This program  
643 is primarily for obstetrical care associated with low birth weight  
644 and pre-term babies. In order to effect cost savings, the  
645 division may develop a revised payment methodology which may  
646 include at-risk capitated payments.

647 (43) The division shall provide reimbursement,  
648 according to a payment schedule developed by the division, for  
649 smoking cessation medications for pregnant women during their



650 pregnancy and other Medicaid-eligible women who are of  
651 child-bearing age.

652 (44) Nursing facility services for the severely  
653 disabled.

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

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

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

668 (46) The division shall make application to the federal  
669 Health Care Financing Administration for a waiver to develop and  
670 provide services for children with serious emotional disturbances  
671 as defined in Section 43-14-1(1), which may include home- and  
672 community-based services, case management services or managed care  
673 services through mental health providers certified by the  
674 Department of Mental Health. The division may implement and  
675 provide services under this waived program only if funds for  
676 these services are specifically appropriated for this purpose by  
677 the Legislature, or if funds are voluntarily provided by affected  
678 agencies.

679 (47) Notwithstanding any other provision in this  
680 article to the contrary, the division is hereby authorized to  
681 develop and implement disease management programs, including the



682 use of grants, waivers, demonstrations or other projects as  
683 necessary.

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

700 Notwithstanding any provision of this article, no new groups  
701 or categories of recipients and new types of care and services may  
702 be added without enabling legislation from the Mississippi  
703 Legislature, except that the division may authorize such changes  
704 without enabling legislation when such addition of recipients or  
705 services is ordered by a court of proper authority. The director  
706 shall keep the Governor advised on a timely basis of the funds  
707 available for expenditure and the projected expenditures. In the  
708 event current or projected expenditures can be reasonably  
709 anticipated to exceed the amounts appropriated for any fiscal  
710 year, the Governor, after consultation with the director, shall  
711 discontinue any or all of the payment of the types of care and  
712 services as provided herein which are deemed to be optional  
713 services under Title XIX of the federal Social Security Act, as  
714 amended, for any period necessary to not exceed appropriated



715 funds, and when necessary shall institute any other cost  
716 containment measures on any program or programs authorized under  
717 the article to the extent allowed under the federal law governing  
718 such program or programs, it being the intent of the Legislature  
719 that expenditures during any fiscal year shall not exceed the  
720 amounts appropriated for such fiscal year.

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

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

734 43-13-121. (1) The division is authorized and empowered to  
735 administer a program of medical assistance under the provisions of  
736 this article, and to do the following:

737 (a) Adopt and promulgate reasonable rules, regulations  
738 and standards, with approval of the Governor, and in accordance  
739 with the Administrative Procedures Law, Section 25-43-1 et seq.:

740 (i) Establishing methods and procedures as may be  
741 necessary for the proper and efficient administration of this  
742 article;

743 (ii) Providing medical assistance to all qualified  
744 recipients under the provisions of this article as the division  
745 may determine and within the limits of appropriated funds;

746 (iii) Establishing reasonable fees, charges and  
747 rates for medical services and drugs; and in doing so shall fix



748 all such fees, charges and rates at the minimum levels absolutely  
749 necessary to provide the medical assistance authorized by this  
750 article, and shall not change any such fees, charges or rates  
751 except as may be authorized in Section 43-13-117;

752 (iv) Providing for fair and impartial hearings;

753 (v) Providing safeguards for preserving the  
754 confidentiality of records; and

755 (vi) For detecting and processing fraudulent  
756 practices and abuses of the program;

757 (b) Receive and expend state, federal and other funds  
758 in accordance with court judgments or settlements and agreements  
759 between the State of Mississippi and the federal government, the  
760 rules and regulations promulgated by the division, with the  
761 approval of the Governor, and within the limitations and  
762 restrictions of this article and within the limits of funds  
763 available for such purpose;

764 (c) Subject to the limits imposed by this article, to  
765 submit a plan for medical assistance to the federal Department of  
766 Health and Human Services for approval pursuant to the provisions  
767 of the Social Security Act, to act for the state in making  
768 negotiations relative to the submission and approval of such plan,  
769 to make such arrangements, not inconsistent with the law, as may  
770 be required by or pursuant to federal law to obtain and retain  
771 such approval and to secure for the state the benefits of the  
772 provisions of such law;

773 No agreements, specifically including the general plan for  
774 the operation of the Medicaid program in this state, shall be made  
775 by and between the division and the Department of Health and Human  
776 Services unless the Attorney General of the State of Mississippi  
777 has reviewed the agreements, specifically including the  
778 operational plan, and has certified in writing to the Governor and  
779 to the director of the division that the agreements, including the



780 plan of operation, have been drawn strictly in accordance with the  
781 terms and requirements of this article;

782 (d) Pursuant to the purposes and intent of this article  
783 and in compliance with its provisions, provide for aged persons  
784 otherwise eligible for the benefits provided under Title XVIII of  
785 the federal Social Security Act by expenditure of funds available  
786 for such purposes;

787 (e) To make reports to the federal Department of Health  
788 and Human Services as from time to time may be required by such  
789 federal department and to the Mississippi Legislature as  
790 hereinafter provided;

791 (f) Define and determine the scope, duration and amount  
792 of medical assistance which may be provided in accordance with  
793 this article and establish priorities therefor in conformity with  
794 this article;

795 (g) Cooperate and contract with other state agencies  
796 for the purpose of coordinating medical assistance rendered under  
797 this article and eliminating duplication and inefficiency in the  
798 program;

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

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

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

806 (k) To recover any and all payments by the division or  
807 by the Medicaid Commission fraudulently obtained by a recipient or  
808 provider. Additionally, if recovery of any payments fraudulently  
809 obtained by a recipient or provider is made in any court, then,  
810 upon motion of the Governor, the judge of the court may award  
811 twice the payments recovered as damages;





812           (1) Have full, complete and plenary power and authority  
813 to conduct such investigations as it may deem necessary and  
814 requisite of alleged or suspected violations or abuses of the  
815 provisions of this article or of the regulations adopted hereunder  
816 including, but not limited to, fraudulent or unlawful act or deed  
817 by applicants for medical assistance or other benefits, or  
818 payments made to any person, firm or corporation under the terms,  
819 conditions and authority of this article, to suspend or disqualify  
820 any provider of services, applicant or recipient for gross abuse,  
821 fraudulent or unlawful acts for such periods, including  
822 permanently, and under such conditions as the division may deem  
823 proper and just, including the imposition of a legal rate of  
824 interest on the amount improperly or incorrectly paid. Recipients  
825 who are found to have misused or abused medical assistance  
826 benefits may be locked into one (1) physician and/or one (1)  
827 pharmacy of the recipient's choice for a reasonable amount of time  
828 in order to educate and promote appropriate use of medical  
829 services, in accordance with federal regulations. Should an  
830 administrative hearing become necessary, the division shall be  
831 authorized, should the provider not succeed in his defense, in  
832 taxing the costs of the administrative hearing, including the  
833 costs of the court reporter or stenographer and transcript, to the  
834 provider. The convictions of a recipient or a provider in a state  
835 or federal court for abuse, fraudulent or unlawful acts under this  
836 chapter shall constitute an automatic disqualification of the  
837 recipient or automatic disqualification of the provider from  
838 participation under the Medicaid program.

839           A conviction, for the purposes of this chapter, shall include  
840 a judgment entered on a plea of nolo contendere or a  
841 nonadjudicated guilty plea and shall have the same force as a  
842 judgment entered pursuant to a guilty plea or a conviction  
843 following trial. A certified copy of the judgment of the court of



844 competent jurisdiction of such conviction shall constitute prima  
845 facie evidence of such conviction for disqualification purposes;

846 (m) Establish and provide such methods of  
847 administration as may be necessary for the proper and efficient  
848 operation of the program, fully utilizing computer equipment as  
849 may be necessary to oversee and control all current expenditures  
850 for purposes of this article, and to closely monitor and supervise  
851 all recipient payments and vendors rendering such services  
852 hereunder;

853 (n) To cooperate and contract with the federal  
854 government for the purpose of providing medical assistance to  
855 Vietnamese and Cambodian refugees, pursuant to the provisions of  
856 Public Law 94-23 and Public Law 94-24, including any amendments  
857 thereto, only to the extent that such assistance and the  
858 administrative cost related thereto are one hundred percent (100%)  
859 reimbursable by the federal government. For the purposes of  
860 Section 43-13-117, persons receiving medical assistance pursuant  
861 to Public Law 94-23 and Public Law 94-24, including any amendments  
862 thereto, shall not be considered a new group or category of  
863 recipient; and

864 (o) The division shall impose penalties upon Medicaid  
865 only, Title XIX participating long-term care facilities found to  
866 be in noncompliance with division and certification standards in  
867 accordance with federal and state regulations, including interest  
868 at the same rate calculated by the Department of Health and Human  
869 Services and/or the Health Care Financing Administration under  
870 federal regulations.

871 (2) The division also shall exercise such additional powers  
872 and perform such other duties as may be conferred upon the  
873 division by act of the Legislature hereafter.

874 (3) The division, and the State Department of Health as the  
875 agency for licensure of health care facilities and certification  
876 and inspection for the Medicaid and/or Medicare programs, shall



877 contract for or otherwise provide for the consolidation of on-site  
878 inspections of health care facilities which are necessitated by  
879 the respective programs and functions of the division and the  
880 department.

881 (4) The division and its hearing officers shall have power  
882 to preserve and enforce order during hearings; to issue subpoenas  
883 for, to administer oaths to and to compel the attendance and  
884 testimony of witnesses, or the production of books, papers,  
885 documents and other evidence, or the taking of depositions before  
886 any designated individual competent to administer oaths; to  
887 examine witnesses; and to do all things conformable to law which  
888 may be necessary to enable them effectively to discharge the  
889 duties of their office. In compelling the attendance and  
890 testimony of witnesses, or the production of books, papers,  
891 documents and other evidence, or the taking of depositions, as  
892 authorized by this section, the division or its hearing officers  
893 may designate an individual employed by the division or some other  
894 suitable person to execute and return such process, whose action  
895 in executing and returning such process shall be as lawful as if  
896 done by the sheriff or some other proper officer authorized to  
897 execute and return process in the county where the witness may  
898 reside. In carrying out the investigatory powers under the  
899 provisions of this article, the director or other designated  
900 person or persons shall be authorized to examine, obtain, copy or  
901 reproduce the books, papers, documents, medical charts,  
902 prescriptions and other records relating to medical care and  
903 services furnished by the provider to a recipient or designated  
904 recipients of Medicaid services under investigation. In the  
905 absence of the voluntary submission of the books, papers,  
906 documents, medical charts, prescriptions and other records, the  
907 Governor, the director, or other designated person shall be  
908 authorized to issue and serve subpoenas instantly upon such  
909 provider, his agent, servant or employee for the production of the



910 books, papers, documents, medical charts, prescriptions or other  
911 records during an audit or investigation of the provider. If any  
912 provider or his agent, servant or employee should refuse to  
913 produce the records after being duly subpoenaed, the director  
914 shall be authorized to certify such facts and institute contempt  
915 proceedings in the manner, time, and place as authorized by law  
916 for administrative proceedings. As an additional remedy, the  
917 division shall be authorized to recover all amounts paid to the  
918 provider covering the period of the audit or investigation,  
919 inclusive of a legal rate of interest and a reasonable attorney's  
920 fee and costs of court if suit becomes necessary. Division staff  
921 shall have immediate access to the provider's physical location,  
922 facilities, records, documents, books, and any other records  
923 relating to medical care and services rendered to recipients  
924 during regular business hours.

925 (5) If any person in proceedings before the division  
926 disobeys or resists any lawful order or process, or misbehaves  
927 during a hearing or so near the place thereof as to obstruct the  
928 same, or neglects to produce, after having been ordered to do so,  
929 any pertinent book, paper or document, or refuses to appear after  
930 having been subpoenaed, or upon appearing refuses to take the oath  
931 as a witness, or after having taken the oath refuses to be  
932 examined according to law, the director shall certify the facts to  
933 any court having jurisdiction in the place in which it is sitting,  
934 and the court shall thereupon, in a summary manner, hear the  
935 evidence as to the acts complained of, and if the evidence so  
936 warrants, punish such person in the same manner and to the same  
937 extent as for a contempt committed before the court, or commit  
938 such person upon the same condition as if the doing of the  
939 forbidden act had occurred with reference to the process of, or in  
940 the presence of, the court.

941 (6) In suspending or terminating any provider from  
942 participation in the Medicaid program, the division shall preclude



943 such provider from submitting claims for payment, either  
944 personally or through any clinic, group, corporation or other  
945 association to the division or its fiscal agents for any services  
946 or supplies provided under the Medicaid program except for those  
947 services or supplies provided prior to the suspension or  
948 termination. No clinic, group, corporation or other association  
949 which is a provider of services shall submit claims for payment to  
950 the division or its fiscal agents for any services or supplies  
951 provided by a person within such organization who has been  
952 suspended or terminated from participation in the Medicaid program  
953 except for those services or supplies provided prior to the  
954 suspension or termination. When this provision is violated by a  
955 provider of services which is a clinic, group, corporation or  
956 other association, the division may suspend or terminate such  
957 organization from participation. Suspension may be applied by the  
958 division to all known affiliates of a provider, provided that each  
959 decision to include an affiliate is made on a case-by-case basis  
960 after giving due regard to all relevant facts and circumstances.  
961 The violation, failure, or inadequacy of performance may be  
962 imputed to a person with whom the provider is affiliated where  
963 such conduct was accomplished with the course of his official duty  
964 or was effectuated by him with the knowledge or approval of such  
965 person.

966       (7) The division may deny or revoke enrollment in the  
967 Medicaid program to a provider if any of the following are found  
968 to be applicable to the provider, his agent, a managing employee,  
969 or any person having an ownership interest equal to five percent  
970 (5%) or greater in the provider:

971           (a) Failure to truthfully or fully disclose any and all  
972 information required, or the concealment of any and all  
973 information required, on a claim, a provider application or a  
974 provider agreement or the making of a false or misleading  
975 statement to the division relative to the Medicaid program.



976 (b) Previous or current exclusion, suspension,  
977 termination from or the involuntary withdrawing from participation  
978 in, the Medicaid program, any other state's Medicaid program,  
979 Medicare or any other public or private health or health insurance  
980 program. If the division ascertains that a provider has been  
981 convicted of a felony under federal or state law for an offense  
982 which the division determines is detrimental to the best interest  
983 of the program or of Medicaid beneficiaries, the division may  
984 refuse to enter into an agreement with such provider, or may  
985 terminate or refuse to renew an existing agreement.

986 (c) Conviction under federal or state law of a criminal  
987 offense relating to the delivery of any goods, services or  
988 supplies, including the performance of management or  
989 administrative services relating to the delivery of the goods,  
990 services or supplies, under the Medicaid program, any other  
991 state's Medicaid program, Medicare or any other public or private  
992 health or health insurance program.

993 (d) Conviction under federal or state law of a criminal  
994 offense relating to the neglect or abuse of a patient in  
995 connection with the delivery of any goods, services or supplies.

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

999 (f) Conviction under federal or state law of a criminal  
1000 offense relating to fraud, theft, embezzlement, breach of  
1001 fiduciary responsibility or other financial misconduct.

1002 (g) Conviction under federal or state law of a criminal  
1003 offense punishable by imprisonment of a year or more which  
1004 involves moral turpitude, or acts against the elderly, children or  
1005 infirm.

1006 (h) Conviction under federal or state law of a criminal  
1007 offense in connection with the interference or obstruction of any



1008 investigation into any criminal offense listed in paragraphs (c)  
1009 through (i) of this subsection.

1010 (i) Sanction pursuant to a violation of federal or  
1011 state laws or rules relative to the Medicaid program, any other  
1012 state's Medicaid program, Medicare or any other public health care  
1013 or health insurance program.

1014 (j) Violation of licensing or certification conditions  
1015 or professional standards relating to the licenses or  
1016 certification of providers or the required quality of goods,  
1017 services or supplies provided.

1018 (k) Failure to pay recovery properly assessed or  
1019 pursuant to an approved repayment schedule under the Medicaid  
1020 program.

1021 (l) Failure to meet any condition of enrollment.

1022 **SECTION 3.** Section 43-13-123, Mississippi Code of 1972, is  
1023 amended as follows:

1024 43-13-123. The determination of the method of providing  
1025 payment of claims under this article shall be made by the  
1026 division, with approval of the Governor, which methods may be:

1027 (1) By contract with insurance companies licensed to do  
1028 business in the State of Mississippi or with nonprofit hospital  
1029 service corporations, medical or dental service corporations,  
1030 authorized to do business in Mississippi to underwrite on an  
1031 insured premium approach, such medical assistance benefits as may  
1032 be available, and any carrier selected pursuant to the provisions  
1033 of this article is hereby expressly authorized and empowered to  
1034 undertake the performance of the requirements of such contract.

1035 (2) By contract with an insurance company licensed to  
1036 do business in the State of Mississippi or with nonprofit hospital  
1037 service, medical or dental service organizations, or other  
1038 organizations including data processing companies, authorized to  
1039 do business in Mississippi to act as fiscal agent.



1040           The division shall obtain services to be provided under  
1041 either of the above-described provisions pursuant to the Personal  
1042 Service Contract Review Board Procurement Regulations.

1043           The authorization of the foregoing methods shall not preclude  
1044 other methods of providing payment of claims through direct  
1045 operation of the program by the state or its agencies.

1046           **SECTION 4.** Section 43-13-145, Mississippi Code of 1972, is  
1047 amended as follows:

1048           43-13-145. (1) Upon each nursing facility licensed or  
1049 certified by the State of Mississippi and each intermediate care  
1050 facility for the mentally retarded licensed by the State of  
1051 Mississippi, there is levied an assessment in an amount set by the  
1052 division not exceeding Two Dollars (\$2.00) per day, or fraction  
1053 thereof, for each \* \* \* licensed or certified bed of the facility.  
1054 The division may apply for a waiver from the U.S. Secretary of  
1055 Health and Human Services to exempt nonprofit, public, charitable  
1056 or religious facilities from the assessment levied under this  
1057 subsection, and if a waiver is granted, such facilities shall be  
1058 exempt from any assessment levied under this subsection after the  
1059 date that the division receives notice that the waiver has been  
1060 granted.

1061           (2) The assessment levied under this section shall be  
1062 collected by the division each quarter beginning on July 1, 1992,  
1063 and shall be based on data for the quarter ending three (3) months  
1064 before the date the assessments are to be collected.

1065           (3) All assessments collected under this section shall be  
1066 deposited in the Medical Care Fund created by Section 43-13-143.

1067           (4) The assessment levied under this section shall be in  
1068 addition to any other assessments, taxes or fees levied by law.

1069           (5) The assessment levied under this section shall  
1070 constitute a debt due the State of Mississippi from the time the  
1071 assessment is due until it is paid. If any facility liable for  
1072 payment of such assessment does not pay the assessment when it is





1073 due, the division shall give written notice to the facility  
1074 demanding payment of the assessment within ten (10) days from the  
1075 date of delivery of the notice. Such notice shall be sent by  
1076 certified or registered mail or delivered to the facility by an  
1077 agent of the division. If any facility liable for the assessment  
1078 fails or refuses to pay it after receiving the notice and demand,  
1079 the division may withhold the Medicaid reimbursement payments that  
1080 are otherwise scheduled to be made to the facility from the time  
1081 the assessment is due until it is paid by the facility.

1082 **SECTION 5.** Section 41-7-191, Mississippi Code of 1972, is  
1083 amended as follows:

1084 41-7-191. (1) No person shall engage in any of the  
1085 following activities without obtaining the required certificate of  
1086 need:

1087 (a) The construction, development or other  
1088 establishment of a new health care facility;

1089 (b) The relocation of a health care facility or portion  
1090 thereof, or major medical equipment, unless such relocation of a  
1091 health care facility or portion thereof, or major medical  
1092 equipment, which does not involve a capital expenditure by or on  
1093 behalf of a health care facility, is within five thousand two  
1094 hundred eighty (5,280) feet from the main entrance of the health  
1095 care facility;

1096 (c) A change over a period of two (2) years' time, as  
1097 established by the State Department of Health, in existing bed  
1098 complement through the addition of more than ten (10) beds or more  
1099 than ten percent (10%) of the total bed capacity of a designated  
1100 licensed category or subcategory of any health care facility,  
1101 whichever is less, from one physical facility or site to another;  
1102 the conversion over a period of two (2) years' time, as  
1103 established by the State Department of Health, of existing bed  
1104 complement of more than ten (10) beds or more than ten percent  
1105 (10%) of the total bed capacity of a designated licensed category



1106 or subcategory of any such health care facility, whichever is  
1107 less; or the alteration, modernizing or refurbishing of any unit  
1108 or department wherein such beds may be located; provided, however,  
1109 that from and after July 1, 1994, no health care facility shall be  
1110 authorized to add any beds or convert any beds to another category  
1111 of beds without a certificate of need under the authority of  
1112 subsection (1)(c) of this section unless there is a projected need  
1113 for such beds in the planning district in which the facility is  
1114 located, as reported in the most current State Health Plan;

1115 (d) Offering of the following health services if those  
1116 services have not been provided on a regular basis by the proposed  
1117 provider of such services within the period of twelve (12) months  
1118 prior to the time such services would be offered:

1119 (i) Open heart surgery services;  
1120 (ii) Cardiac catheterization services;  
1121 (iii) Comprehensive inpatient rehabilitation  
1122 services;  
1123 (iv) Licensed psychiatric services;  
1124 (v) Licensed chemical dependency services;  
1125 (vi) Radiation therapy services;  
1126 (vii) Diagnostic imaging services of an invasive  
1127 nature, i.e. invasive digital angiography;

1128 (viii) Nursing home care as defined in  
1129 subparagraphs (iv), (vi) and (viii) of Section 41-7-173(h);

1130 (ix) Home health services;  
1131 (x) Swing-bed services;  
1132 (xi) Ambulatory surgical services;  
1133 (xii) Magnetic resonance imaging services;  
1134 (xiii) Extracorporeal shock wave lithotripsy  
1135 services;

1136 (xiv) Long-term care hospital services;

1137 (xv) Positron Emission Tomography (PET) services;



1138           (e) The relocation of one or more health services from  
1139 one physical facility or site to another physical facility or  
1140 site, unless such relocation, which does not involve a capital  
1141 expenditure by or on behalf of a health care facility, (i) is to a  
1142 physical facility or site within one thousand three hundred twenty  
1143 (1,320) feet from the main entrance of the health care facility  
1144 where the health care service is located, or (ii) is the result of  
1145 an order of a court of appropriate jurisdiction or a result of  
1146 pending litigation in such court, or by order of the State  
1147 Department of Health, or by order of any other agency or legal  
1148 entity of the state, the federal government, or any political  
1149 subdivision of either, whose order is also approved by the State  
1150 Department of Health;

1151           (f) The acquisition or otherwise control of any major  
1152 medical equipment for the provision of medical services; provided,  
1153 however, (i) the acquisition of any major medical equipment used  
1154 only for research purposes, and (ii) the acquisition of major  
1155 medical equipment to replace medical equipment for which a  
1156 facility is already providing medical services and for which the  
1157 State Department of Health has been notified before the date of  
1158 such acquisition shall be exempt from this paragraph; an  
1159 acquisition for less than fair market value must be reviewed, if  
1160 the acquisition at fair market value would be subject to review;

1161           (g) Changes of ownership of existing health care  
1162 facilities in which a notice of intent is not filed with the State  
1163 Department of Health at least thirty (30) days prior to the date  
1164 such change of ownership occurs, or a change in services or bed  
1165 capacity as prescribed in paragraph (c) or (d) of this subsection  
1166 as a result of the change of ownership; an acquisition for less  
1167 than fair market value must be reviewed, if the acquisition at  
1168 fair market value would be subject to review;

1169           (h) The change of ownership of any health care facility  
1170 defined in subparagraphs (iv), (vi) and (viii) of Section



1171 41-7-173(h), in which a notice of intent as described in paragraph  
1172 (g) has not been filed and if the Executive Director, Division of  
1173 Medicaid, Office of the Governor, has not certified in writing  
1174 that there will be no increase in allowable costs to Medicaid from  
1175 revaluation of the assets or from increased interest and  
1176 depreciation as a result of the proposed change of ownership;

1177 (i) Any activity described in paragraphs (a) through  
1178 (h) if undertaken by any person if that same activity would  
1179 require certificate of need approval if undertaken by a health  
1180 care facility;

1181 (j) Any capital expenditure or deferred capital  
1182 expenditure by or on behalf of a health care facility not covered  
1183 by paragraphs (a) through (h);

1184 (k) The contracting of a health care facility as  
1185 defined in subparagraphs (i) through (viii) of Section 41-7-173(h)  
1186 to establish a home office, subunit, or branch office in the space  
1187 operated as a health care facility through a formal arrangement  
1188 with an existing health care facility as defined in subparagraph  
1189 (ix) of Section 41-7-173(h).

1190 (2) The State Department of Health shall not grant approval  
1191 for or issue a certificate of need to any person proposing the new  
1192 construction of, addition to, or expansion of any health care  
1193 facility defined in subparagraphs (iv) (skilled nursing facility)  
1194 and (vi) (intermediate care facility) of Section 41-7-173(h) or  
1195 the conversion of vacant hospital beds to provide skilled or  
1196 intermediate nursing home care, except as hereinafter authorized:

1197 (a) The department may issue a certificate of need to  
1198 any person proposing the new construction of any health care  
1199 facility defined in subparagraphs (iv) and (vi) of Section  
1200 41-7-173(h) as part of a life care retirement facility, in any  
1201 county bordering on the Gulf of Mexico in which is located a  
1202 National Aeronautics and Space Administration facility, not to  
1203 exceed forty (40) beds. From and after July 1, 1999, there shall



1204 be no prohibition or restrictions on participation in the Medicaid  
1205 program (Section 43-13-101 et seq.) for the beds in the health  
1206 care facility that were authorized under this paragraph (a).

1207 (b) The department may issue certificates of need in  
1208 Harrison County to provide skilled nursing home care for  
1209 Alzheimer's Disease patients and other patients, not to exceed one  
1210 hundred fifty (150) beds. From and after July 1, 1999, there  
1211 shall be no prohibition or restrictions on participation in the  
1212 Medicaid program (Section 43-13-101 et seq.) for the beds in the  
1213 nursing facilities that were authorized under this paragraph (b).

1214 (c) The department may issue a certificate of need for  
1215 the addition to or expansion of any skilled nursing facility that  
1216 is part of an existing continuing care retirement community  
1217 located in Madison County, provided that the recipient of the  
1218 certificate of need agrees in writing that the skilled nursing  
1219 facility will not at any time participate in the Medicaid program  
1220 (Section 43-13-101 et seq.) or admit or keep any patients in the  
1221 skilled nursing facility who are participating in the Medicaid  
1222 program. This written agreement by the recipient of the  
1223 certificate of need shall be fully binding on any subsequent owner  
1224 of the skilled nursing facility, if the ownership of the facility  
1225 is transferred at any time after the issuance of the certificate  
1226 of need. Agreement that the skilled nursing facility will not  
1227 participate in the Medicaid program shall be a condition of the  
1228 issuance of a certificate of need to any person under this  
1229 paragraph (c), and if such skilled nursing facility at any time  
1230 after the issuance of the certificate of need, regardless of the  
1231 ownership of the facility, participates in the Medicaid program or  
1232 admits or keeps any patients in the facility who are participating  
1233 in the Medicaid program, the State Department of Health shall  
1234 revoke the certificate of need, if it is still outstanding, and  
1235 shall deny or revoke the license of the skilled nursing facility,  
1236 at the time that the department determines, after a hearing



1237 complying with due process, that the facility has failed to comply  
1238 with any of the conditions upon which the certificate of need was  
1239 issued, as provided in this paragraph and in the written agreement  
1240 by the recipient of the certificate of need. The total number of  
1241 beds that may be authorized under the authority of this paragraph  
1242 (c) shall not exceed sixty (60) beds.

1243 (d) The State Department of Health may issue a  
1244 certificate of need to any hospital located in DeSoto County for  
1245 the new construction of a skilled nursing facility, not to exceed  
1246 one hundred twenty (120) beds, in DeSoto County. From and after  
1247 July 1, 1999, there shall be no prohibition or restrictions on  
1248 participation in the Medicaid program (Section 43-13-101 et seq.)  
1249 for the beds in the nursing facility that were authorized under  
1250 this paragraph (d).

1251 (e) The State Department of Health may issue a  
1252 certificate of need for the construction of a nursing facility or  
1253 the conversion of beds to nursing facility beds at a personal care  
1254 facility for the elderly in Lowndes County that is owned and  
1255 operated by a Mississippi nonprofit corporation, not to exceed  
1256 sixty (60) beds. From and after July 1, 1999, there shall be no  
1257 prohibition or restrictions on participation in the Medicaid  
1258 program (Section 43-13-101 et seq.) for the beds in the nursing  
1259 facility that were authorized under this paragraph (e).

1260 (f) The State Department of Health may issue a  
1261 certificate of need for conversion of a county hospital facility  
1262 in Itawamba County to a nursing facility, not to exceed sixty (60)  
1263 beds, including any necessary construction, renovation or  
1264 expansion. From and after July 1, 1999, there shall be no  
1265 prohibition or restrictions on participation in the Medicaid  
1266 program (Section 43-13-101 et seq.) for the beds in the nursing  
1267 facility that were authorized under this paragraph (f).

1268 (g) The State Department of Health may issue a  
1269 certificate of need for the construction or expansion of nursing



1270 facility beds or the conversion of other beds to nursing facility  
1271 beds in either Hinds, Madison or Rankin Counties, not to exceed  
1272 sixty (60) beds. From and after July 1, 1999, there shall be no  
1273 prohibition or restrictions on participation in the Medicaid  
1274 program (Section 43-13-101 et seq.) for the beds in the nursing  
1275 facility that were authorized under this paragraph (g).

1276 (h) The State Department of Health may issue a  
1277 certificate of need for the construction or expansion of nursing  
1278 facility beds or the conversion of other beds to nursing facility  
1279 beds in either Hancock, Harrison or Jackson Counties, not to  
1280 exceed sixty (60) beds. From and after July 1, 1999, there shall  
1281 be no prohibition or restrictions on participation in the Medicaid  
1282 program (Section 43-13-101 et seq.) for the beds in the facility  
1283 that were authorized under this paragraph (h).

1284 (i) The department may issue a certificate of need for  
1285 the new construction of a skilled nursing facility in Leake  
1286 County, provided that the recipient of the certificate of need  
1287 agrees in writing that the skilled nursing facility will not at  
1288 any time participate in the Medicaid program (Section 43-13-101 et  
1289 seq.) or admit or keep any patients in the skilled nursing  
1290 facility who are participating in the Medicaid program. This  
1291 written agreement by the recipient of the certificate of need  
1292 shall be fully binding on any subsequent owner of the skilled  
1293 nursing facility, if the ownership of the facility is transferred  
1294 at any time after the issuance of the certificate of need.  
1295 Agreement that the skilled nursing facility will not participate  
1296 in the Medicaid program shall be a condition of the issuance of a  
1297 certificate of need to any person under this paragraph (i), and if  
1298 such skilled nursing facility at any time after the issuance of  
1299 the certificate of need, regardless of the ownership of the  
1300 facility, participates in the Medicaid program or admits or keeps  
1301 any patients in the facility who are participating in the Medicaid  
1302 program, the State Department of Health shall revoke the



1303 certificate of need, if it is still outstanding, and shall deny or  
1304 revoke the license of the skilled nursing facility, at the time  
1305 that the department determines, after a hearing complying with due  
1306 process, that the facility has failed to comply with any of the  
1307 conditions upon which the certificate of need was issued, as  
1308 provided in this paragraph and in the written agreement by the  
1309 recipient of the certificate of need. The provision of Section  
1310 43-7-193(1) regarding substantial compliance of the projection of  
1311 need as reported in the current State Health Plan is waived for  
1312 the purposes of this paragraph. The total number of nursing  
1313 facility beds that may be authorized by any certificate of need  
1314 issued under this paragraph (i) shall not exceed sixty (60) beds.  
1315 If the skilled nursing facility authorized by the certificate of  
1316 need issued under this paragraph is not constructed and fully  
1317 operational within eighteen (18) months after July 1, 1994, the  
1318 State Department of Health, after a hearing complying with due  
1319 process, shall revoke the certificate of need, if it is still  
1320 outstanding, and shall not issue a license for the skilled nursing  
1321 facility at any time after the expiration of the eighteen-month  
1322 period.

1323           (j) The department may issue certificates of need to  
1324 allow any existing freestanding long-term care facility in  
1325 Tishomingo County and Hancock County that on July 1, 1995, is  
1326 licensed with fewer than sixty (60) beds. For the purposes of  
1327 this paragraph (j), the provision of Section 41-7-193(1) requiring  
1328 substantial compliance with the projection of need as reported in  
1329 the current State Health Plan is waived. From and after July 1,  
1330 1999, there shall be no prohibition or restrictions on  
1331 participation in the Medicaid program (Section 43-13-101 et seq.)  
1332 for the beds in the long-term care facilities that were authorized  
1333 under this paragraph (j).

1334           (k) The department may issue a certificate of need for  
1335 the construction of a nursing facility at a continuing care





1336 retirement community in Lowndes County. The total number of beds  
1337 that may be authorized under the authority of this paragraph (k)  
1338 shall not exceed sixty (60) beds. From and after July 1, 2001,  
1339 the prohibition on the facility participating in the Medicaid  
1340 program (Section 43-13-101 et seq.) that was a condition of  
1341 issuance of the certificate of need under this paragraph (k) shall  
1342 be revised as follows: The nursing facility may participate in  
1343 the Medicaid program from and after July 1, 2001, if the owner of  
1344 the facility on July 1, 2001, agrees in writing that no more than  
1345 thirty (30) of the beds at the facility will be certified for  
1346 participation in the Medicaid program, and that no claim will be  
1347 submitted for Medicaid reimbursement for more than thirty (30)  
1348 patients in the facility in any month or for any patient in the  
1349 facility who is in a bed that is not Medicaid-certified. This  
1350 written agreement by the owner of the facility shall be a  
1351 condition of licensure of the facility, and the agreement shall be  
1352 fully binding on any subsequent owner of the facility if the  
1353 ownership of the facility is transferred at any time after July 1,  
1354 2001. After this written agreement is executed, the Division of  
1355 Medicaid and the State Department of Health shall not certify more  
1356 than thirty (30) of the beds in the facility for participation in  
1357 the Medicaid program. If the facility violates the terms of the  
1358 written agreement by admitting or keeping in the facility on a  
1359 regular or continuing basis more than thirty (30) patients who are  
1360 participating in the Medicaid program, the State Department of  
1361 Health shall revoke the license of the facility, at the time that  
1362 the department determines, after a hearing complying with due  
1363 process, that the facility has violated the written agreement.

1364 (1) Provided that funds are specifically appropriated  
1365 therefor by the Legislature, the department may issue a  
1366 certificate of need to a rehabilitation hospital in Hinds County  
1367 for the construction of a sixty-bed long-term care nursing  
1368 facility dedicated to the care and treatment of persons with



1369 severe disabilities including persons with spinal cord and  
1370 closed-head injuries and ventilator-dependent patients. The  
1371 provision of Section 41-7-193(1) regarding substantial compliance  
1372 with projection of need as reported in the current State Health  
1373 Plan is hereby waived for the purpose of this paragraph.

1374 (m) The State Department of Health may issue a  
1375 certificate of need to a county-owned hospital in the Second  
1376 Judicial District of Panola County for the conversion of not more  
1377 than seventy-two (72) hospital beds to nursing facility beds,  
1378 provided that the recipient of the certificate of need agrees in  
1379 writing that none of the beds at the nursing facility will be  
1380 certified for participation in the Medicaid program (Section  
1381 43-13-101 et seq.), and that no claim will be submitted for  
1382 Medicaid reimbursement in the nursing facility in any day or for  
1383 any patient in the nursing facility. This written agreement by  
1384 the recipient of the certificate of need shall be a condition of  
1385 the issuance of the certificate of need under this paragraph, and  
1386 the agreement shall be fully binding on any subsequent owner of  
1387 the nursing facility if the ownership of the nursing facility is  
1388 transferred at any time after the issuance of the certificate of  
1389 need. After this written agreement is executed, the Division of  
1390 Medicaid and the State Department of Health shall not certify any  
1391 of the beds in the nursing facility for participation in the  
1392 Medicaid program. If the nursing facility violates the terms of  
1393 the written agreement by admitting or keeping in the nursing  
1394 facility on a regular or continuing basis any patients who are  
1395 participating in the Medicaid program, the State Department of  
1396 Health shall revoke the license of the nursing facility, at the  
1397 time that the department determines, after a hearing complying  
1398 with due process, that the nursing facility has violated the  
1399 condition upon which the certificate of need was issued, as  
1400 provided in this paragraph and in the written agreement. If the  
1401 certificate of need authorized under this paragraph is not issued



1402 within twelve (12) months after July 1, 2001, the department shall  
1403 deny the application for the certificate of need and shall not  
1404 issue the certificate of need at any time after the twelve-month  
1405 period, unless the issuance is contested. If the certificate of  
1406 need is issued and substantial construction of the nursing  
1407 facility beds has not commenced within eighteen (18) months after  
1408 July 1, 2001, the State Department of Health, after a hearing  
1409 complying with due process, shall revoke the certificate of need  
1410 if it is still outstanding, and the department shall not issue a  
1411 license for the nursing facility at any time after the  
1412 eighteen-month period. Provided, however, that if the issuance of  
1413 the certificate of need is contested, the department shall require  
1414 substantial construction of the nursing facility beds within six  
1415 (6) months after final adjudication on the issuance of the  
1416 certificate of need.

1417 (n) The department may issue a certificate of need for  
1418 the new construction, addition or conversion of skilled nursing  
1419 facility beds in Madison County, provided that the recipient of  
1420 the certificate of need agrees in writing that the skilled nursing  
1421 facility will not at any time participate in the Medicaid program  
1422 (Section 43-13-101 et seq.) or admit or keep any patients in the  
1423 skilled nursing facility who are participating in the Medicaid  
1424 program. This written agreement by the recipient of the  
1425 certificate of need shall be fully binding on any subsequent owner  
1426 of the skilled nursing facility, if the ownership of the facility  
1427 is transferred at any time after the issuance of the certificate  
1428 of need. Agreement that the skilled nursing facility will not  
1429 participate in the Medicaid program shall be a condition of the  
1430 issuance of a certificate of need to any person under this  
1431 paragraph (n), and if such skilled nursing facility at any time  
1432 after the issuance of the certificate of need, regardless of the  
1433 ownership of the facility, participates in the Medicaid program or  
1434 admits or keeps any patients in the facility who are participating



1435 in the Medicaid program, the State Department of Health shall  
1436 revoke the certificate of need, if it is still outstanding, and  
1437 shall deny or revoke the license of the skilled nursing facility,  
1438 at the time that the department determines, after a hearing  
1439 complying with due process, that the facility has failed to comply  
1440 with any of the conditions upon which the certificate of need was  
1441 issued, as provided in this paragraph and in the written agreement  
1442 by the recipient of the certificate of need. The total number of  
1443 nursing facility beds that may be authorized by any certificate of  
1444 need issued under this paragraph (n) shall not exceed sixty (60)  
1445 beds. If the certificate of need authorized under this paragraph  
1446 is not issued within twelve (12) months after July 1, 1998, the  
1447 department shall deny the application for the certificate of need  
1448 and shall not issue the certificate of need at any time after the  
1449 twelve-month period, unless the issuance is contested. If the  
1450 certificate of need is issued and substantial construction of the  
1451 nursing facility beds has not commenced within eighteen (18)  
1452 months after the effective date of July 1, 1998, the State  
1453 Department of Health, after a hearing complying with due process,  
1454 shall revoke the certificate of need if it is still outstanding,  
1455 and the department shall not issue a license for the nursing  
1456 facility at any time after the eighteen-month period. Provided,  
1457 however, that if the issuance of the certificate of need is  
1458 contested, the department shall require substantial construction  
1459 of the nursing facility beds within six (6) months after final  
1460 adjudication on the issuance of the certificate of need.

1461 (o) The department may issue a certificate of need for  
1462 the new construction, addition or conversion of skilled nursing  
1463 facility beds in Leake County, provided that the recipient of the  
1464 certificate of need agrees in writing that the skilled nursing  
1465 facility will not at any time participate in the Medicaid program  
1466 (Section 43-13-101 et seq.) or admit or keep any patients in the  
1467 skilled nursing facility who are participating in the Medicaid



1468 program. This written agreement by the recipient of the  
1469 certificate of need shall be fully binding on any subsequent owner  
1470 of the skilled nursing facility, if the ownership of the facility  
1471 is transferred at any time after the issuance of the certificate  
1472 of need. Agreement that the skilled nursing facility will not  
1473 participate in the Medicaid program shall be a condition of the  
1474 issuance of a certificate of need to any person under this  
1475 paragraph (o), and if such skilled nursing facility at any time  
1476 after the issuance of the certificate of need, regardless of the  
1477 ownership of the facility, participates in the Medicaid program or  
1478 admits or keeps any patients in the facility who are participating  
1479 in the Medicaid program, the State Department of Health shall  
1480 revoke the certificate of need, if it is still outstanding, and  
1481 shall deny or revoke the license of the skilled nursing facility,  
1482 at the time that the department determines, after a hearing  
1483 complying with due process, that the facility has failed to comply  
1484 with any of the conditions upon which the certificate of need was  
1485 issued, as provided in this paragraph and in the written agreement  
1486 by the recipient of the certificate of need. The total number of  
1487 nursing facility beds that may be authorized by any certificate of  
1488 need issued under this paragraph (o) shall not exceed sixty (60)  
1489 beds. If the certificate of need authorized under this paragraph  
1490 is not issued within twelve (12) months after July 1, 2001, the  
1491 department shall deny the application for the certificate of need  
1492 and shall not issue the certificate of need at any time after the  
1493 twelve-month period, unless the issuance is contested. If the  
1494 certificate of need is issued and substantial construction of the  
1495 nursing facility beds has not commenced within eighteen (18)  
1496 months after the effective date of July 1, 2001, the State  
1497 Department of Health, after a hearing complying with due process,  
1498 shall revoke the certificate of need if it is still outstanding,  
1499 and the department shall not issue a license for the nursing  
1500 facility at any time after the eighteen-month period. Provided,



1501 however, that if the issuance of the certificate of need is  
1502 contested, the department shall require substantial construction  
1503 of the nursing facility beds within six (6) months after final  
1504 adjudication on the issuance of the certificate of need.

1505 (p) The department may issue a certificate of need for  
1506 the construction of a municipally-owned nursing facility within  
1507 the Town of Belmont in Tishomingo County, not to exceed sixty (60)  
1508 beds, provided that the recipient of the certificate of need  
1509 agrees in writing that the skilled nursing facility will not at  
1510 any time participate in the Medicaid program (Section 43-13-101 et  
1511 seq.) or admit or keep any patients in the skilled nursing  
1512 facility who are participating in the Medicaid program. This  
1513 written agreement by the recipient of the certificate of need  
1514 shall be fully binding on any subsequent owner of the skilled  
1515 nursing facility, if the ownership of the facility is transferred  
1516 at any time after the issuance of the certificate of need.

1517 Agreement that the skilled nursing facility will not participate  
1518 in the Medicaid program shall be a condition of the issuance of a  
1519 certificate of need to any person under this paragraph (p), and if  
1520 such skilled nursing facility at any time after the issuance of  
1521 the certificate of need, regardless of the ownership of the  
1522 facility, participates in the Medicaid program or admits or keeps  
1523 any patients in the facility who are participating in the Medicaid  
1524 program, the State Department of Health shall revoke the  
1525 certificate of need, if it is still outstanding, and shall deny or  
1526 revoke the license of the skilled nursing facility, at the time  
1527 that the department determines, after a hearing complying with due  
1528 process, that the facility has failed to comply with any of the  
1529 conditions upon which the certificate of need was issued, as  
1530 provided in this paragraph and in the written agreement by the  
1531 recipient of the certificate of need. The provision of Section  
1532 43-7-193(1) regarding substantial compliance of the projection of  
1533 need as reported in the current State Health Plan is waived for



1534 the purposes of this paragraph. If the certificate of need  
1535 authorized under this paragraph is not issued within twelve (12)  
1536 months after July 1, 1998, the department shall deny the  
1537 application for the certificate of need and shall not issue the  
1538 certificate of need at any time after the twelve-month period,  
1539 unless the issuance is contested. If the certificate of need is  
1540 issued and substantial construction of the nursing facility beds  
1541 has not commenced within eighteen (18) months after July 1, 1998,  
1542 the State Department of Health, after a hearing complying with due  
1543 process, shall revoke the certificate of need if it is still  
1544 outstanding, and the department shall not issue a license for the  
1545 nursing facility at any time after the eighteen-month period.  
1546 Provided, however, that if the issuance of the certificate of need  
1547 is contested, the department shall require substantial  
1548 construction of the nursing facility beds within six (6) months  
1549 after final adjudication on the issuance of the certificate of  
1550 need.

1551 (q) (i) Beginning on July 1, 1999, the State  
1552 Department of Health shall issue certificates of need during each  
1553 of the next four (4) fiscal years for the construction or  
1554 expansion of nursing facility beds or the conversion of other beds  
1555 to nursing facility beds in each county in the state having a need  
1556 for fifty (50) or more additional nursing facility beds, as shown  
1557 in the fiscal year 1999 State Health Plan, in the manner provided  
1558 in this paragraph (q). The total number of nursing facility beds  
1559 that may be authorized by any certificate of need authorized under  
1560 this paragraph (q) shall not exceed sixty (60) beds.

1561 (ii) Subject to the provisions of subparagraph  
1562 (v), during each of the next four (4) fiscal years, the department  
1563 shall issue six (6) certificates of need for new nursing facility  
1564 beds, as follows: During fiscal years 2000, 2001 and 2002, one  
1565 (1) certificate of need shall be issued for new nursing facility  
1566 beds in the county in each of the four (4) Long-Term Care Planning



1567 Districts designated in the fiscal year 1999 State Health Plan  
1568 that has the highest need in the district for those beds; and two  
1569 (2) certificates of need shall be issued for new nursing facility  
1570 beds in the two (2) counties from the state at large that have the  
1571 highest need in the state for those beds, when considering the  
1572 need on a statewide basis and without regard to the Long-Term Care  
1573 Planning Districts in which the counties are located. During  
1574 fiscal year 2003, one (1) certificate of need shall be issued for  
1575 new nursing facility beds in any county having a need for fifty  
1576 (50) or more additional nursing facility beds, as shown in the  
1577 fiscal year 1999 State Health Plan, that has not received a  
1578 certificate of need under this paragraph (q) during the three (3)  
1579 previous fiscal years. During fiscal year 2000, in addition to  
1580 the six (6) certificates of need authorized in this subparagraph,  
1581 the department also shall issue a certificate of need for new  
1582 nursing facility beds in Amite County and a certificate of need  
1583 for new nursing facility beds in Carroll County.

1584 (iii) Subject to the provisions of subparagraph  
1585 (v), the certificate of need issued under subparagraph (ii) for  
1586 nursing facility beds in each Long-Term Care Planning District  
1587 during each fiscal year shall first be available for nursing  
1588 facility beds in the county in the district having the highest  
1589 need for those beds, as shown in the fiscal year 1999 State Health  
1590 Plan. If there are no applications for a certificate of need for  
1591 nursing facility beds in the county having the highest need for  
1592 those beds by the date specified by the department, then the  
1593 certificate of need shall be available for nursing facility beds  
1594 in other counties in the district in descending order of the need  
1595 for those beds, from the county with the second highest need to  
1596 the county with the lowest need, until an application is received  
1597 for nursing facility beds in an eligible county in the district.

1598 (iv) Subject to the provisions of subparagraph  
1599 (v), the certificate of need issued under subparagraph (ii) for





1600 nursing facility beds in the two (2) counties from the state at  
1601 large during each fiscal year shall first be available for nursing  
1602 facility beds in the two (2) counties that have the highest need  
1603 in the state for those beds, as shown in the fiscal year 1999  
1604 State Health Plan, when considering the need on a statewide basis  
1605 and without regard to the Long-Term Care Planning Districts in  
1606 which the counties are located. If there are no applications for  
1607 a certificate of need for nursing facility beds in either of the  
1608 two (2) counties having the highest need for those beds on a  
1609 statewide basis by the date specified by the department, then the  
1610 certificate of need shall be available for nursing facility beds  
1611 in other counties from the state at large in descending order of  
1612 the need for those beds on a statewide basis, from the county with  
1613 the second highest need to the county with the lowest need, until  
1614 an application is received for nursing facility beds in an  
1615 eligible county from the state at large.

1616 (v) If a certificate of need is authorized to be  
1617 issued under this paragraph (q) for nursing facility beds in a  
1618 county on the basis of the need in the Long-Term Care Planning  
1619 District during any fiscal year of the four-year period, a  
1620 certificate of need shall not also be available under this  
1621 paragraph (q) for additional nursing facility beds in that county  
1622 on the basis of the need in the state at large, and that county  
1623 shall be excluded in determining which counties have the highest  
1624 need for nursing facility beds in the state at large for that  
1625 fiscal year. After a certificate of need has been issued under  
1626 this paragraph (q) for nursing facility beds in a county during  
1627 any fiscal year of the four-year period, a certificate of need  
1628 shall not be available again under this paragraph (q) for  
1629 additional nursing facility beds in that county during the  
1630 four-year period, and that county shall be excluded in determining  
1631 which counties have the highest need for nursing facility beds in  
1632 succeeding fiscal years.



1633                   (vi) If more than one (1) application is made for  
1634 a certificate of need for nursing home facility beds available  
1635 under this paragraph (q), in Yalobusha, Newton or Tallahatchie  
1636 County, and one (1) of the applicants is a county-owned hospital  
1637 located in the county where the nursing facility beds are  
1638 available, the department shall give priority to the county-owned  
1639 hospital in granting the certificate of need if the following  
1640 conditions are met:

1641                   1. The county-owned hospital fully meets all  
1642 applicable criteria and standards required to obtain a certificate  
1643 of need for the nursing facility beds; and

1644                   2. The county-owned hospital's qualifications  
1645 for the certificate of need, as shown in its application and as  
1646 determined by the department, are at least equal to the  
1647 qualifications of the other applicants for the certificate of  
1648 need.

1649                   (r) (i) Beginning on July 1, 1999, the State  
1650 Department of Health shall issue certificates of need during each  
1651 of the next two (2) fiscal years for the construction or expansion  
1652 of nursing facility beds or the conversion of other beds to  
1653 nursing facility beds in each of the four (4) Long-Term Care  
1654 Planning Districts designated in the fiscal year 1999 State Health  
1655 Plan, to provide care exclusively to patients with Alzheimer's  
1656 disease.

1657                   (ii) Not more than twenty (20) beds may be  
1658 authorized by any certificate of need issued under this paragraph  
1659 (r), and not more than a total of sixty (60) beds may be  
1660 authorized in any Long-Term Care Planning District by all  
1661 certificates of need issued under this paragraph (r). However,  
1662 the total number of beds that may be authorized by all  
1663 certificates of need issued under this paragraph (r) during any  
1664 fiscal year shall not exceed one hundred twenty (120) beds, and  
1665 the total number of beds that may be authorized in any Long-Term



1666 Care Planning District during any fiscal year shall not exceed  
1667 forty (40) beds. Of the certificates of need that are issued for  
1668 each Long-Term Care Planning District during the next two (2)  
1669 fiscal years, at least one (1) shall be issued for beds in the  
1670 northern part of the district, at least one (1) shall be issued  
1671 for beds in the central part of the district, and at least one (1)  
1672 shall be issued for beds in the southern part of the district.

1673 (iii) The State Department of Health, in  
1674 consultation with the Department of Mental Health and the Division  
1675 of Medicaid, shall develop and prescribe the staffing levels,  
1676 space requirements and other standards and requirements that must  
1677 be met with regard to the nursing facility beds authorized under  
1678 this paragraph (r) to provide care exclusively to patients with  
1679 Alzheimer's disease.

1680 (3) The State Department of Health may grant approval for  
1681 and issue certificates of need to any person proposing the new  
1682 construction of, addition to, conversion of beds of or expansion  
1683 of any health care facility defined in subparagraph (x)  
1684 (psychiatric residential treatment facility) of Section  
1685 41-7-173(h). The total number of beds which may be authorized by  
1686 such certificates of need shall not exceed three hundred  
1687 thirty-four (334) beds for the entire state.

1688 (a) Of the total number of beds authorized under this  
1689 subsection, the department shall issue a certificate of need to a  
1690 privately owned psychiatric residential treatment facility in  
1691 Simpson County for the conversion of sixteen (16) intermediate  
1692 care facility for the mentally retarded (ICF-MR) beds to  
1693 psychiatric residential treatment facility beds, provided that  
1694 facility agrees in writing that the facility shall give priority  
1695 for the use of those sixteen (16) beds to Mississippi residents  
1696 who are presently being treated in out-of-state facilities.

1697 (b) Of the total number of beds authorized under this  
1698 subsection, the department may issue a certificate or certificates



1699 of need for the construction or expansion of psychiatric  
1700 residential treatment facility beds or the conversion of other  
1701 beds to psychiatric residential treatment facility beds in Warren  
1702 County, not to exceed sixty (60) psychiatric residential treatment  
1703 facility beds, provided that the facility agrees in writing that  
1704 no more than thirty (30) of the beds at the psychiatric  
1705 residential treatment facility will be certified for participation  
1706 in the Medicaid program (Section 43-13-101 et seq.) for the use of  
1707 any patients other than those who are participating only in the  
1708 Medicaid program of another state, and that no claim will be  
1709 submitted to the Division of Medicaid for Medicaid reimbursement  
1710 for more than thirty (30) patients in the psychiatric residential  
1711 treatment facility in any day or for any patient in the  
1712 psychiatric residential treatment facility who is in a bed that is  
1713 not Medicaid-certified. This written agreement by the recipient  
1714 of the certificate of need shall be a condition of the issuance of  
1715 the certificate of need under this paragraph, and the agreement  
1716 shall be fully binding on any subsequent owner of the psychiatric  
1717 residential treatment facility if the ownership of the facility is  
1718 transferred at any time after the issuance of the certificate of  
1719 need. After this written agreement is executed, the Division of  
1720 Medicaid and the State Department of Health shall not certify more  
1721 than thirty (30) of the beds in the psychiatric residential  
1722 treatment facility for participation in the Medicaid program for  
1723 the use of any patients other than those who are participating  
1724 only in the Medicaid program of another state. If the psychiatric  
1725 residential treatment facility violates the terms of the written  
1726 agreement by admitting or keeping in the facility on a regular or  
1727 continuing basis more than thirty (30) patients who are  
1728 participating in the Mississippi Medicaid program, the State  
1729 Department of Health shall revoke the license of the facility, at  
1730 the time that the department determines, after a hearing complying  
1731 with due process, that the facility has violated the condition



1732 upon which the certificate of need was issued, as provided in this  
1733 paragraph and in the written agreement.

1734         If by January 1, 2002, there has been no significant  
1735 commencement of construction of the beds authorized under this  
1736 paragraph (b), or no significant action taken to convert existing  
1737 beds to the beds authorized under this paragraph, then the  
1738 certificate of need that was previously issued under this  
1739 paragraph shall expire. If the previously issued certificate of  
1740 need expires, the department may accept applications for issuance  
1741 of another certificate of need for the beds authorized under this  
1742 paragraph, and may issue a certificate of need to authorize the  
1743 construction, expansion or conversion of the beds authorized under  
1744 this paragraph.

1745         (c) Of the total number of beds authorized under this  
1746 subsection, the department shall issue a certificate of need to a  
1747 hospital currently operating Medicaid-certified acute psychiatric  
1748 beds for adolescents in DeSoto County, for the establishment of a  
1749 forty-bed psychiatric residential treatment facility in DeSoto  
1750 County, provided that the hospital agrees in writing (i) that the  
1751 hospital shall give priority for the use of those forty (40) beds  
1752 to Mississippi residents who are presently being treated in  
1753 out-of-state facilities, and (ii) that no more than fifteen (15)  
1754 of the beds at the psychiatric residential treatment facility will  
1755 be certified for participation in the Medicaid program (Section  
1756 43-13-101 et seq.), and that no claim will be submitted for  
1757 Medicaid reimbursement for more than fifteen (15) patients in the  
1758 psychiatric residential treatment facility in any day or for any  
1759 patient in the psychiatric residential treatment facility who is  
1760 in a bed that is not Medicaid-certified. This written agreement  
1761 by the recipient of the certificate of need shall be a condition  
1762 of the issuance of the certificate of need under this paragraph,  
1763 and the agreement shall be fully binding on any subsequent owner  
1764 of the psychiatric residential treatment facility if the ownership



1765 of the facility is transferred at any time after the issuance of  
1766 the certificate of need. After this written agreement is  
1767 executed, the Division of Medicaid and the State Department of  
1768 Health shall not certify more than fifteen (15) of the beds in the  
1769 psychiatric residential treatment facility for participation in  
1770 the Medicaid program. If the psychiatric residential treatment  
1771 facility violates the terms of the written agreement by admitting  
1772 or keeping in the facility on a regular or continuing basis more  
1773 than fifteen (15) patients who are participating in the Medicaid  
1774 program, the State Department of Health shall revoke the license  
1775 of the facility, at the time that the department determines, after  
1776 a hearing complying with due process, that the facility has  
1777 violated the condition upon which the certificate of need was  
1778 issued, as provided in this paragraph and in the written  
1779 agreement.

1780 (d) Of the total number of beds authorized under this  
1781 subsection, the department may issue a certificate or certificates  
1782 of need for the construction or expansion of psychiatric  
1783 residential treatment facility beds or the conversion of other  
1784 beds to psychiatric treatment facility beds, not to exceed thirty  
1785 (30) psychiatric residential treatment facility beds, in either  
1786 Alcorn, Tishomingo, Prentiss, Lee, Itawamba, Monroe, Chickasaw,  
1787 Pontotoc, Calhoun, Lafayette, Union, Benton or Tippah Counties.

1788 (e) Of the total number of beds authorized under this  
1789 subsection (3) the department shall issue a certificate of need to  
1790 a privately owned, nonprofit psychiatric residential treatment  
1791 facility in Hinds County for an eight-bed expansion of the  
1792 facility, provided that the facility agrees in writing that the  
1793 facility shall give priority for the use of those eight (8) beds  
1794 to Mississippi residents who are presently being treated in  
1795 out-of-state facilities.

1796 (f) The department shall issue a certificate of need to  
1797 a one-hundred-thirty-four-bed specialty hospital located on



1798 twenty-nine and forty-four one-hundredths (29.44) commercial acres  
1799 at 5900 Highway 39 North in Meridian (Lauderdale County),  
1800 Mississippi, for the addition, construction or expansion of  
1801 child/adolescent psychiatric residential treatment facility beds  
1802 in Lauderdale County. As a condition of issuance of the  
1803 certificate of need under this paragraph, the facility shall give  
1804 priority in admissions to the child/adolescent psychiatric  
1805 residential treatment facility beds authorized under this  
1806 paragraph to patients who otherwise would require out-of-state  
1807 placement. \* \* \* For purposes of this paragraph, the provisions  
1808 of Section 41-7-193(1) requiring substantial compliance with the  
1809 projection of need as reported in the current State Health Plan  
1810 are waived. The total number of child/adolescent psychiatric  
1811 residential treatment facility beds that may be authorized under  
1812 the authority of this paragraph shall be sixty (60) beds. There  
1813 shall be no prohibition or restrictions on participation in the  
1814 Medicaid program (Section 43-13-101 et seq.) for the person  
1815 receiving the certificate of need authorized under this paragraph  
1816 or for the beds converted pursuant to the authority of that  
1817 certificate of need.

1818 (4) (a) From and after July 1, 1993, the department shall  
1819 not issue a certificate of need to any person for the new  
1820 construction of any hospital, psychiatric hospital or chemical  
1821 dependency hospital that will contain any child/adolescent  
1822 psychiatric or child/adolescent chemical dependency beds, or for  
1823 the conversion of any other health care facility to a hospital,  
1824 psychiatric hospital or chemical dependency hospital that will  
1825 contain any child/adolescent psychiatric or child/adolescent  
1826 chemical dependency beds, or for the addition of any  
1827 child/adolescent psychiatric or child/adolescent chemical  
1828 dependency beds in any hospital, psychiatric hospital or chemical  
1829 dependency hospital, or for the conversion of any beds of another  
1830 category in any hospital, psychiatric hospital or chemical



1831 dependency hospital to child/adolescent psychiatric or  
1832 child/adolescent chemical dependency beds, except as hereinafter  
1833 authorized:

1834                   (i) The department may issue certificates of need  
1835 to any person for any purpose described in this subsection,  
1836 provided that the hospital, psychiatric hospital or chemical  
1837 dependency hospital does not participate in the Medicaid program  
1838 (Section 43-13-101 et seq.) at the time of the application for the  
1839 certificate of need and the owner of the hospital, psychiatric  
1840 hospital or chemical dependency hospital agrees in writing that  
1841 the hospital, psychiatric hospital or chemical dependency hospital  
1842 will not at any time participate in the Medicaid program or admit  
1843 or keep any patients who are participating in the Medicaid program  
1844 in the hospital, psychiatric hospital or chemical dependency  
1845 hospital. This written agreement by the recipient of the  
1846 certificate of need shall be fully binding on any subsequent owner  
1847 of the hospital, psychiatric hospital or chemical dependency  
1848 hospital, if the ownership of the facility is transferred at any  
1849 time after the issuance of the certificate of need. Agreement  
1850 that the hospital, psychiatric hospital or chemical dependency  
1851 hospital will not participate in the Medicaid program shall be a  
1852 condition of the issuance of a certificate of need to any person  
1853 under this subparagraph (a)(i), and if such hospital, psychiatric  
1854 hospital or chemical dependency hospital at any time after the  
1855 issuance of the certificate of need, regardless of the ownership  
1856 of the facility, participates in the Medicaid program or admits or  
1857 keeps any patients in the hospital, psychiatric hospital or  
1858 chemical dependency hospital who are participating in the Medicaid  
1859 program, the State Department of Health shall revoke the  
1860 certificate of need, if it is still outstanding, and shall deny or  
1861 revoke the license of the hospital, psychiatric hospital or  
1862 chemical dependency hospital, at the time that the department  
1863 determines, after a hearing complying with due process, that the





1864 hospital, psychiatric hospital or chemical dependency hospital has  
1865 failed to comply with any of the conditions upon which the  
1866 certificate of need was issued, as provided in this subparagraph  
1867 and in the written agreement by the recipient of the certificate  
1868 of need.

1869           (ii) The department may issue a certificate of  
1870 need for the conversion of existing beds in a county hospital in  
1871 Choctaw County from acute care beds to child/adolescent chemical  
1872 dependency beds. For purposes of this subparagraph, the  
1873 provisions of Section 41-7-193(1) requiring substantial compliance  
1874 with the projection of need as reported in the current State  
1875 Health Plan is waived. The total number of beds that may be  
1876 authorized under authority of this subparagraph shall not exceed  
1877 twenty (20) beds. There shall be no prohibition or restrictions  
1878 on participation in the Medicaid program (Section 43-13-101 et  
1879 seq.) for the hospital receiving the certificate of need  
1880 authorized under this subparagraph (a)(ii) or for the beds  
1881 converted pursuant to the authority of that certificate of need.

1882           (iii) The department may issue a certificate or  
1883 certificates of need for the construction or expansion of  
1884 child/adolescent psychiatric beds or the conversion of other beds  
1885 to child/adolescent psychiatric beds in Warren County. For  
1886 purposes of this subparagraph, the provisions of Section  
1887 41-7-193(1) requiring substantial compliance with the projection  
1888 of need as reported in the current State Health Plan are waived.  
1889 The total number of beds that may be authorized under the  
1890 authority of this subparagraph shall not exceed twenty (20) beds.  
1891 There shall be no prohibition or restrictions on participation in  
1892 the Medicaid program (Section 43-13-101 et seq.) for the person  
1893 receiving the certificate of need authorized under this  
1894 subparagraph (a)(iii) or for the beds converted pursuant to the  
1895 authority of that certificate of need.



1896           If by January 1, 2002, there has been no significant  
1897 commencement of construction of the beds authorized under this  
1898 subparagraph (a)(iii), or no significant action taken to convert  
1899 existing beds to the beds authorized under this subparagraph, then  
1900 the certificate of need that was previously issued under this  
1901 subparagraph shall expire. If the previously issued certificate  
1902 of need expires, the department may accept applications for  
1903 issuance of another certificate of need for the beds authorized  
1904 under this subparagraph, and may issue a certificate of need to  
1905 authorize the construction, expansion or conversion of the beds  
1906 authorized under this subparagraph.

1907                       (iv) The department shall issue a certificate of  
1908 need to the Region 7 Mental Health/Retardation Commission for the  
1909 construction or expansion of child/adolescent psychiatric beds or  
1910 the conversion of other beds to child/adolescent psychiatric beds  
1911 in any of the counties served by the commission. For purposes of  
1912 this subparagraph, the provisions of Section 41-7-193(1) requiring  
1913 substantial compliance with the projection of need as reported in  
1914 the current State Health Plan is waived. The total number of beds  
1915 that may be authorized under the authority of this subparagraph  
1916 shall not exceed twenty (20) beds. There shall be no prohibition  
1917 or restrictions on participation in the Medicaid program (Section  
1918 43-13-101 et seq.) for the person receiving the certificate of  
1919 need authorized under this subparagraph (a)(iv) or for the beds  
1920 converted pursuant to the authority of that certificate of need.

1921                       (v) The department may issue a certificate of need  
1922 to any county hospital located in Leflore County for the  
1923 construction or expansion of adult psychiatric beds or the  
1924 conversion of other beds to adult psychiatric beds, not to exceed  
1925 twenty (20) beds, provided that the recipient of the certificate  
1926 of need agrees in writing that the adult psychiatric beds will not  
1927 at any time be certified for participation in the Medicaid program  
1928 and that the hospital will not admit or keep any patients who are



1929 participating in the Medicaid program in any of such adult  
1930 psychiatric beds. This written agreement by the recipient of the  
1931 certificate of need shall be fully binding on any subsequent owner  
1932 of the hospital if the ownership of the hospital is transferred at  
1933 any time after the issuance of the certificate of need. Agreement  
1934 that the adult psychiatric beds will not be certified for  
1935 participation in the Medicaid program shall be a condition of the  
1936 issuance of a certificate of need to any person under this  
1937 subparagraph (a)(v), and if such hospital at any time after the  
1938 issuance of the certificate of need, regardless of the ownership  
1939 of the hospital, has any of such adult psychiatric beds certified  
1940 for participation in the Medicaid program or admits or keeps any  
1941 Medicaid patients in such adult psychiatric beds, the State  
1942 Department of Health shall revoke the certificate of need, if it  
1943 is still outstanding, and shall deny or revoke the license of the  
1944 hospital at the time that the department determines, after a  
1945 hearing complying with due process, that the hospital has failed  
1946 to comply with any of the conditions upon which the certificate of  
1947 need was issued, as provided in this subparagraph and in the  
1948 written agreement by the recipient of the certificate of need.

1949                   (vi) The department may issue a certificate or  
1950 certificates of need for the expansion of child psychiatric beds  
1951 or the conversion of other beds to child psychiatric beds at the  
1952 University of Mississippi Medical Center. For purposes of this  
1953 subparagraph (a)(vi), the provision of Section 41-7-193(1)  
1954 requiring substantial compliance with the projection of need as  
1955 reported in the current State Health Plan is waived. The total  
1956 number of beds that may be authorized under the authority of this  
1957 subparagraph (a)(vi) shall not exceed fifteen (15) beds. There  
1958 shall be no prohibition or restrictions on participation in the  
1959 Medicaid program (Section 43-13-101 et seq.) for the hospital  
1960 receiving the certificate of need authorized under this



1961 subparagraph (a) (vi) or for the beds converted pursuant to the  
1962 authority of that certificate of need.

1963 (b) From and after July 1, 1990, no hospital,  
1964 psychiatric hospital or chemical dependency hospital shall be  
1965 authorized to add any child/adolescent psychiatric or  
1966 child/adolescent chemical dependency beds or convert any beds of  
1967 another category to child/adolescent psychiatric or  
1968 child/adolescent chemical dependency beds without a certificate of  
1969 need under the authority of subsection (1) (c) of this section.

1970 (5) The department may issue a certificate of need to a  
1971 county hospital in Winston County for the conversion of fifteen  
1972 (15) acute care beds to geriatric psychiatric care beds.

1973 (6) The State Department of Health shall issue a certificate  
1974 of need to a Mississippi corporation qualified to manage a  
1975 long-term care hospital as defined in Section 41-7-173(h) (xii) in  
1976 Harrison County, not to exceed eighty (80) beds, including any  
1977 necessary renovation or construction required for licensure and  
1978 certification, provided that the recipient of the certificate of  
1979 need agrees in writing that the long-term care hospital will not  
1980 at any time participate in the Medicaid program (Section 43-13-101  
1981 et seq.) or admit or keep any patients in the long-term care  
1982 hospital who are participating in the Medicaid program. This  
1983 written agreement by the recipient of the certificate of need  
1984 shall be fully binding on any subsequent owner of the long-term  
1985 care hospital, if the ownership of the facility is transferred at  
1986 any time after the issuance of the certificate of need. Agreement  
1987 that the long-term care hospital will not participate in the  
1988 Medicaid program shall be a condition of the issuance of a  
1989 certificate of need to any person under this subsection (6), and  
1990 if such long-term care hospital at any time after the issuance of  
1991 the certificate of need, regardless of the ownership of the  
1992 facility, participates in the Medicaid program or admits or keeps  
1993 any patients in the facility who are participating in the Medicaid



1994 program, the State Department of Health shall revoke the  
1995 certificate of need, if it is still outstanding, and shall deny or  
1996 revoke the license of the long-term care hospital, at the time  
1997 that the department determines, after a hearing complying with due  
1998 process, that the facility has failed to comply with any of the  
1999 conditions upon which the certificate of need was issued, as  
2000 provided in this subsection and in the written agreement by the  
2001 recipient of the certificate of need. For purposes of this  
2002 subsection, the provision of Section 41-7-193(1) requiring  
2003 substantial compliance with the projection of need as reported in  
2004 the current State Health Plan is hereby waived.

2005 (7) The State Department of Health may issue a certificate  
2006 of need to any hospital in the state to utilize a portion of its  
2007 beds for the "swing-bed" concept. Any such hospital must be in  
2008 conformance with the federal regulations regarding such swing-bed  
2009 concept at the time it submits its application for a certificate  
2010 of need to the State Department of Health, except that such  
2011 hospital may have more licensed beds or a higher average daily  
2012 census (ADC) than the maximum number specified in federal  
2013 regulations for participation in the swing-bed program. Any  
2014 hospital meeting all federal requirements for participation in the  
2015 swing-bed program which receives such certificate of need shall  
2016 render services provided under the swing-bed concept to any  
2017 patient eligible for Medicare (Title XVIII of the Social Security  
2018 Act) who is certified by a physician to be in need of such  
2019 services, and no such hospital shall permit any patient who is  
2020 eligible for both Medicaid and Medicare or eligible only for  
2021 Medicaid to stay in the swing beds of the hospital for more than  
2022 thirty (30) days per admission unless the hospital receives prior  
2023 approval for such patient from the Division of Medicaid, Office of  
2024 the Governor. Any hospital having more licensed beds or a higher  
2025 average daily census (ADC) than the maximum number specified in  
2026 federal regulations for participation in the swing-bed program



2027 which receives such certificate of need shall develop a procedure  
2028 to insure that before a patient is allowed to stay in the swing  
2029 beds of the hospital, there are no vacant nursing home beds  
2030 available for that patient located within a fifty-mile radius of  
2031 the hospital. When any such hospital has a patient staying in the  
2032 swing beds of the hospital and the hospital receives notice from a  
2033 nursing home located within such radius that there is a vacant bed  
2034 available for that patient, the hospital shall transfer the  
2035 patient to the nursing home within a reasonable time after receipt  
2036 of the notice. Any hospital which is subject to the requirements  
2037 of the two (2) preceding sentences of this subsection may be  
2038 suspended from participation in the swing-bed program for a  
2039 reasonable period of time by the State Department of Health if the  
2040 department, after a hearing complying with due process, determines  
2041 that the hospital has failed to comply with any of those  
2042 requirements.

2043 (8) The Department of Health shall not grant approval for or  
2044 issue a certificate of need to any person proposing the new  
2045 construction of, addition to or expansion of a health care  
2046 facility as defined in subparagraph (viii) of Section 41-7-173(h).

2047 (9) The Department of Health shall not grant approval for or  
2048 issue a certificate of need to any person proposing the  
2049 establishment of, or expansion of the currently approved territory  
2050 of, or the contracting to establish a home office, subunit or  
2051 branch office within the space operated as a health care facility  
2052 as defined in Section 41-7-173(h)(i) through (viii) by a health  
2053 care facility as defined in subparagraph (ix) of Section  
2054 41-7-173(h).

2055 (10) Health care facilities owned and/or operated by the  
2056 state or its agencies are exempt from the restraints in this  
2057 section against issuance of a certificate of need if such addition  
2058 or expansion consists of repairing or renovation necessary to  
2059 comply with the state licensure law. This exception shall not



2060 apply to the new construction of any building by such state  
2061 facility. This exception shall not apply to any health care  
2062 facilities owned and/or operated by counties, municipalities,  
2063 districts, unincorporated areas, other defined persons, or any  
2064 combination thereof.

2065 (11) The new construction, renovation or expansion of or  
2066 addition to any health care facility defined in subparagraph (ii)  
2067 (psychiatric hospital), subparagraph (iv) (skilled nursing  
2068 facility), subparagraph (vi) (intermediate care facility),  
2069 subparagraph (viii) (intermediate care facility for the mentally  
2070 retarded) and subparagraph (x) (psychiatric residential treatment  
2071 facility) of Section 41-7-173(h) which is owned by the State of  
2072 Mississippi and under the direction and control of the State  
2073 Department of Mental Health, and the addition of new beds or the  
2074 conversion of beds from one category to another in any such  
2075 defined health care facility which is owned by the State of  
2076 Mississippi and under the direction and control of the State  
2077 Department of Mental Health, shall not require the issuance of a  
2078 certificate of need under Section 41-7-171 et seq.,  
2079 notwithstanding any provision in Section 41-7-171 et seq. to the  
2080 contrary.

2081 (12) The new construction, renovation or expansion of or  
2082 addition to any veterans homes or domiciliaries for eligible  
2083 veterans of the State of Mississippi as authorized under Section  
2084 35-1-19 shall not require the issuance of a certificate of need,  
2085 notwithstanding any provision in Section 41-7-171 et seq. to the  
2086 contrary.

2087 (13) The new construction of a nursing facility or nursing  
2088 facility beds or the conversion of other beds to nursing facility  
2089 beds shall not require the issuance of a certificate of need,  
2090 notwithstanding any provision in Section 41-7-171 et seq. to the  
2091 contrary, if the conditions of this subsection are met.



2092           (a) Before any construction or conversion may be  
2093 undertaken without a certificate of need, the owner of the nursing  
2094 facility, in the case of an existing facility, or the applicant to  
2095 construct a nursing facility, in the case of new construction,  
2096 first must file a written notice of intent and sign a written  
2097 agreement with the State Department of Health that the entire  
2098 nursing facility will not at any time participate in or have any  
2099 beds certified for participation in the Medicaid program (Section  
2100 43-13-101 et seq.), will not admit or keep any patients in the  
2101 nursing facility who are participating in the Medicaid program,  
2102 and will not submit any claim for Medicaid reimbursement for any  
2103 patient in the facility. This written agreement by the owner or  
2104 applicant shall be a condition of exercising the authority under  
2105 this subsection without a certificate of need, and the agreement  
2106 shall be fully binding on any subsequent owner of the nursing  
2107 facility if the ownership of the facility is transferred at any  
2108 time after the agreement is signed. After the written agreement  
2109 is signed, the Division of Medicaid and the State Department of  
2110 Health shall not certify any beds in the nursing facility for  
2111 participation in the Medicaid program. If the nursing facility  
2112 violates the terms of the written agreement by participating in  
2113 the Medicaid program, having any beds certified for participation  
2114 in the Medicaid program, admitting or keeping any patient in the  
2115 facility who is participating in the Medicaid program, or  
2116 submitting any claim for Medicaid reimbursement for any patient in  
2117 the facility, the State Department of Health shall revoke the  
2118 license of the nursing facility at the time that the department  
2119 determines, after a hearing complying with due process, that the  
2120 facility has violated the terms of the written agreement.

2121           (b) For the purposes of this subsection, participation  
2122 in the Medicaid program by a nursing facility includes Medicaid  
2123 reimbursement of coinsurance and deductibles for recipients who  
2124 are qualified Medicare beneficiaries and/or those who are dually





2125 eligible. Any nursing facility exercising the authority under  
2126 this subsection may not bill or submit a claim to the Division of  
2127 Medicaid for services to qualified Medicare beneficiaries and/or  
2128 those who are dually eligible.

2129 (c) The new construction of a nursing facility or  
2130 nursing facility beds or the conversion of other beds to nursing  
2131 facility beds described in this section must be either a part of a  
2132 completely new continuing care retirement community, as described  
2133 in the latest edition of the Mississippi State Health Plan, or an  
2134 addition to existing personal care and independent living  
2135 components, and so that the completed project will be a continuing  
2136 care retirement community, containing (i) independent living  
2137 accommodations, (ii) personal care beds, and (iii) the nursing  
2138 home facility beds. The three (3) components must be located on a  
2139 single site and be operated as one (1) inseparable facility. The  
2140 nursing facility component must contain a minimum of thirty (30)  
2141 beds. Any nursing facility beds authorized by this section will  
2142 not be counted against the bed need set forth in the State Health  
2143 Plan, as identified in Section 41-7-171, et seq.

2144 This subsection (13) shall stand repealed from and after July  
2145 1, 2005.

2146 (14) The State Department of Health shall issue a  
2147 certificate of need to any hospital which is currently licensed  
2148 for two hundred fifty (250) or more acute care beds and is located  
2149 in any general hospital service area not having a comprehensive  
2150 cancer center, for the establishment and equipping of such a  
2151 center which provides facilities and services for outpatient  
2152 radiation oncology therapy, outpatient medical oncology therapy,  
2153 and appropriate support services including the provision of  
2154 radiation therapy services. The provision of Section 41-7-193(1)  
2155 regarding substantial compliance with the projection of need as  
2156 reported in the current State Health Plan is waived for the  
2157 purpose of this subsection.



2158           (15) The State Department of Health may authorize the  
2159 transfer of hospital beds, not to exceed sixty (60) beds, from the  
2160 North Panola Community Hospital to the South Panola Community  
2161 Hospital. The authorization for the transfer of those beds shall  
2162 be exempt from the certificate of need review process.

2163           (16) Nothing in this section or in any other provision of  
2164 Section 41-7-171 et seq. shall prevent any nursing facility from  
2165 designating an appropriate number of existing beds in the facility  
2166 as beds for providing care exclusively to patients with  
2167 Alzheimer's disease.

2168           **SECTION 6.** The following shall be codified as Section  
2169 11-11-8, Mississippi Code of 1972:

2170           11-11-8. Actions against nursing homes and other long term  
2171 care providers for injury or damages or wrongful death, whether in  
2172 contract or tort, based on an alleged breach of the standard of  
2173 care must be brought in the county in which the act or omission  
2174 constituting the alleged breach of the standard of care by the  
2175 defendant actually occurred. If the act or omissions took place  
2176 in more than one (1) county within the State of Mississippi, the  
2177 action must be brought in the county in which the plaintiff  
2178 resided at the time of the act or omission, if the action is for  
2179 personal injuries, or in which the plaintiff's decedent resided at  
2180 the time of the act or omission, if the action is for wrongful  
2181 death. If at any time before the beginning of the trial of the  
2182 action it is shown that the plaintiff's injuries or plaintiff's  
2183 decedent's death did not result from acts or omissions that took  
2184 place in more than one (1) county, on motion of any defendant the  
2185 court shall transfer the action to the county in which the alleged  
2186 acts or omissions actually occurred.

2187           If an action is brought in an improper county, the action may  
2188 be transferred to the proper county under Section 11-11-17.

2189           **SECTION 7.** Section 15-1-36, Mississippi Code of 1972, is  
2190 amended as follows:



2191 15-1-36. (1) For any claim accruing on or before June 30,  
2192 1998, and except as otherwise provided in this section, no claim  
2193 in tort may be brought against a licensed physician, osteopath,  
2194 dentist, hospital, nursing home or other long-term care facility,  
2195 nurse, pharmacist, podiatrist, optometrist or chiropractor for  
2196 injuries or wrongful death arising out of the course of medical,  
2197 surgical or other professional services unless it is filed within  
2198 two (2) years from the date the alleged act, omission or neglect  
2199 shall or with reasonable diligence might have been first known or  
2200 discovered.

2201 (2) For any claim accruing on or after July 1, 1998, and  
2202 except as otherwise provided in this section, no claim in tort may  
2203 be brought against a licensed physician, osteopath, dentist,  
2204 hospital, nursing home or other long-term care facility, nurse,  
2205 pharmacist, podiatrist, optometrist or chiropractor for injuries  
2206 or wrongful death arising out of the course of medical, surgical  
2207 or other professional services unless it is filed within two (2)  
2208 years from the date the alleged act, omission or neglect shall or  
2209 with reasonable diligence might have been first known or  
2210 discovered, and, except as described in paragraphs (a) and (b) of  
2211 this subsection, in no event more than seven (7) years after the  
2212 alleged act, omission or neglect occurred:

2213 (a) In the event a foreign object introduced during a  
2214 surgical or medical procedure has been left in a patient's body,  
2215 the cause of action shall be deemed to have first accrued at, and  
2216 not before, the time at which the foreign object is, or with  
2217 reasonable diligence should have been, first known or discovered  
2218 to be in the patient's body.

2219 (b) In the event the cause of action shall have been  
2220 fraudulently concealed from the knowledge of the person entitled  
2221 thereto, the cause of action shall be deemed to have first accrued  
2222 at, and not before, the time at which such fraud shall be, or with  
2223 reasonable diligence should have been, first known or discovered.



2224           (3) Except as otherwise provided in subsection (4) of this  
2225 section, if at the time at which the cause of action shall or with  
2226 reasonable diligence might have been first known or discovered,  
2227 the person to whom such claim has accrued shall be six (6) years  
2228 of age or younger, then such minor or the person claiming through  
2229 such minor may, notwithstanding that the period of time limited  
2230 pursuant to subsections (1) and (2) of this section shall have  
2231 expired, commence action on such claim at any time within two (2)  
2232 years next after the time at which the minor shall have reached  
2233 his sixth birthday, or shall have died, whichever shall have first  
2234 occurred.

2235           (4) If at the time at which the cause of action shall or  
2236 with reasonable diligence might have been first known or  
2237 discovered, the person to whom such claim has accrued shall be a  
2238 minor without a parent or legal guardian, then such minor or the  
2239 person claiming through such minor may, notwithstanding that the  
2240 period of time limited pursuant to subsections (1) and (2) of this  
2241 section shall have expired, commence action on such claim at any  
2242 time within two (2) years next after the time at which the minor  
2243 shall have a parent or legal guardian or shall have died,  
2244 whichever shall have first occurred; \* \* \* however, \* \* \* in no  
2245 event shall the period of limitation begin to run prior to such  
2246 minor's sixth birthday unless such minor shall have died.

2247           (5) If at the time at which the cause of action shall or  
2248 with reasonable diligence might have been first known or  
2249 discovered, the person to whom such claim has accrued shall be  
2250 under the disability of unsoundness of mind, then such person or  
2251 the person claiming through him may, notwithstanding that the  
2252 period of time hereinbefore limited shall have expired, commence  
2253 action on such claim at any time within two (2) years next after  
2254 the time at which the person to whom the right shall have first  
2255 accrued shall have ceased to be under the disability, or shall  
2256 have died, whichever shall have first occurred.



2257           (6) When any person who shall be under the disabilities  
2258 mentioned in subsections (3), (4) and (5) of this section at the  
2259 time at which his right shall have first accrued, shall depart  
2260 this life without having ceased to be under such disability, no  
2261 time shall be allowed by reason of the disability of such person  
2262 to commence action on the claim of such person beyond the period  
2263 prescribed under Section 15-1-55, Mississippi Code of 1972.

2264           (7) For the purposes of subsection (3) of this section, and  
2265 only for the purposes of such subsection, the disability of  
2266 infancy or minority shall be removed from and after a person has  
2267 reached his sixth birthday.

2268           (8) For the purposes of subsection (4) of this section, and  
2269 only for the purposes of such subsection, the disability of  
2270 infancy or minority shall be removed from and after a person has  
2271 reached his sixth birthday or from and after such person shall  
2272 have a parent or legal guardian, whichever occurs later, unless  
2273 such disability is otherwise removed by law.

2274           (9) The limitation established by this section as to a  
2275 licensed physician, osteopath, dentist, hospital or nurse shall  
2276 apply only to actions the cause of which accrued on or after July  
2277 1, 1976.

2278           (10) The limitation established by this section as to  
2279 pharmacists shall apply only to actions the cause of which accrued  
2280 on or after July 1, 1978.

2281           (11) The limitation established by this section as to  
2282 podiatrists shall apply only to actions the cause of which accrued  
2283 on or after July 1, 1979.

2284           (12) The limitation established by this section as to  
2285 optometrists and chiropractors shall apply only to actions the  
2286 cause of which accrued on or after July 1, 1983.

2287           (13) The limitation established by this section as to  
2288 actions commenced on behalf of minors shall apply only to actions  
2289 the cause of which accrued on or after July 1, 1989.



2290           **SECTION 8.** Section 43-11-7, Mississippi Code of 1972, is  
2291 amended as follows:

2292           43-11-7. Any person, as defined in Section 43-11-1, may  
2293 apply for a license as provided in this section. An application  
2294 for a license shall be made to the licensing agency upon forms  
2295 provided by it and shall contain such information as the licensing  
2296 agency reasonably requires, which may include affirmative evidence  
2297 of ability to comply with such reasonable standards, rules and  
2298 regulations as are lawfully prescribed hereunder. Each  
2299 application for a license for an institution for the aged or  
2300 infirm, except for personal care homes, shall be accompanied by a  
2301 license fee of Twenty Dollars (\$20.00) for each bed in the  
2302 institution, with a minimum fee per institution of Two Hundred  
2303 Dollars (\$200.00), which shall be paid to the licensing agency.  
2304 Each application for a license for a personal care home shall be  
2305 accompanied by a license fee of Fifteen Dollars (\$15.00) for each  
2306 bed in the institution, with a minimum fee per institution of One  
2307 Hundred Dollars (\$100.00), which shall be paid to the licensing  
2308 agency.

2309           No governmental entity or agency shall be required to pay the  
2310 fee or fees set forth in this section.

2311           **SECTION 9.** Section 43-11-13, Mississippi Code of 1972, is  
2312 amended as follows:

2313           43-11-13. (1) The licensing agency shall adopt, amend,  
2314 promulgate and enforce such rules, regulations and standards,  
2315 including classifications, with respect to all institutions for  
2316 the aged or infirm to be licensed under this chapter as may be  
2317 designed to further the accomplishment of the purpose of this  
2318 chapter in promoting adequate care of individuals in such  
2319 institutions in the interest of public health, safety and welfare.  
2320 Nothing contained in these or any other rules, regulations or  
2321 standards promulgated or enforced by the licensing agency shall be  
2322 construed as establishing a medical standard of care. Such rules,



2323 regulations and standards shall be adopted and promulgated by the  
2324 licensing agency and shall be recorded and indexed in a book to be  
2325 maintained by the licensing agency in its main office in the State  
2326 of Mississippi, entitled "Rules, Regulations and Minimum Standards  
2327 for Institutions for the Aged or Infirm" and the book shall be  
2328 open and available to all institutions for the aged or infirm and  
2329 the public generally at all reasonable times. Upon the adoption  
2330 of such rules, regulations and standards, the licensing agency  
2331 shall mail copies thereof to all such institutions in the state  
2332 which have filed with the agency their names and addresses for  
2333 this purpose, but the failure to mail the same or the failure of  
2334 the institutions to receive the same shall in no way affect the  
2335 validity thereof. The rules, regulations and standards may be  
2336 amended by the licensing agency, from time to time, as necessary  
2337 to promote the health, safety and welfare of persons living in  
2338 those institutions.

2339       (2) The licensee shall keep posted in a conspicuous place on  
2340 the licensed premises all current rules, regulations and minimum  
2341 standards applicable to fire protection measures as adopted by the  
2342 licensing agency. The licensee shall furnish to the licensing  
2343 agency at least once each six (6) months a certificate of approval  
2344 and inspection by state or local fire authorities. Failure to  
2345 comply with state laws and/or municipal ordinances and current  
2346 rules, regulations and minimum standards as adopted by the  
2347 licensing agency, relative to fire prevention measures, shall be  
2348 prima facie evidence for revocation of license.

2349       (3) The State Board of Health shall promulgate rules and  
2350 regulations restricting the storage, quantity and classes of drugs  
2351 allowed in personal care homes. Residents requiring  
2352 administration of Schedule II Narcotics as defined in the Uniform  
2353 Controlled Substances Law may be admitted to a personal care home.  
2354 Schedule drugs may only be allowed in a personal care home if they



2355 are administered or stored utilizing proper procedures under the  
2356 direct supervision of a licensed physician or nurse.

2357 (4) (a) Notwithstanding any determination by the licensing  
2358 agency that skilled nursing services would be appropriate for a  
2359 resident of a personal care home, that resident, the resident's  
2360 guardian or the legally recognized responsible party for the  
2361 resident may consent in writing for the resident to continue to  
2362 reside in the personal care home, if approved in writing by a  
2363 licensed physician. \* \* \* However, \* \* \* no personal care home  
2364 shall allow more than two (2) residents, or ten percent (10%) of  
2365 the total number of residents in the facility, whichever is  
2366 greater, to remain in the personal care home under the provisions  
2367 of this subsection (4). This consent shall be deemed to be  
2368 appropriately informed consent as described in the regulations  
2369 promulgated by the licensing agency. After that written consent  
2370 has been obtained, the resident shall have the right to continue  
2371 to reside in the personal care home for as long as the resident  
2372 meets the other conditions for residing in the personal care home.  
2373 A copy of the written consent and the physician's approval shall  
2374 be forwarded by the personal care home to the licensing agency.

2375 (b) The State Board of Health shall promulgate rules  
2376 and regulations restricting the handling of a resident's personal  
2377 deposits by the director of a personal care home. Any funds given  
2378 or provided for the purpose of supplying extra comforts,  
2379 conveniences or services to any patient in any personal care home,  
2380 and any funds otherwise received and held from, for or on behalf  
2381 of any such resident, shall be deposited by the director or other  
2382 proper officer of the personal care home to the credit of that  
2383 patient in an account which shall be known as the Resident's  
2384 Personal Deposit Fund. No more than one (1) month charge for the  
2385 care, support, maintenance and medical attention of the patient  
2386 shall be applied from such account at any one time. After the  
2387 death, discharge or transfer of any resident for whose benefit any





2388 such fund has been provided, any unexpended balance remaining in  
2389 his personal deposit fund shall be applied for the payment of  
2390 care, cost of support, maintenance and medical attention which is  
2391 accrued. In the event any unexpended balance remains in that  
2392 resident's personal deposit fund after complete reimbursement has  
2393 been made for payment of care, support, maintenance and medical  
2394 attention, and the director or other proper officer of the  
2395 personal care home has been or shall be unable to locate the  
2396 person or persons entitled to such unexpended balance, the  
2397 director or other proper officer may, after the lapse of one (1)  
2398 year from the date of such death, discharge or transfer, deposit  
2399 the unexpended balance to the credit of the personal care home's  
2400 operating fund.

2401 (c) The State Board of Health shall promulgate rules  
2402 and regulations requiring personal care homes to maintain records  
2403 relating to health condition, medicine dispensed and administered,  
2404 and any reaction to such medicine. The director of the personal  
2405 care home shall be responsible for explaining the availability of  
2406 such records to the family of the resident at any time upon  
2407 reasonable request.

2408 (d) The State Board of Health shall evaluate the  
2409 effects of this section as it promotes adequate care of  
2410 individuals in personal care homes in the interest of public  
2411 health, safety and welfare. It shall report its findings to the  
2412 Chairmen of the Public Health and Welfare Committees of the House  
2413 and Senate by January 1, 2003. This subsection (4) shall stand  
2414 repealed June 30, 2003.

2415 (5) (a) Pursuant to regulations promulgated by the State  
2416 Department of Health, the licensing agency shall require to be  
2417 performed a criminal history record check on every new employee of  
2418 a licensed institution for the aged or infirm or care facility who  
2419 provides direct patient care or services and who is employed after  
2420 July 1, 2001. Except as otherwise provided, no such new employee



2421 shall be permitted to provide direct patient care or services  
2422 until the results of the criminal history record check have  
2423 revealed no disqualifying record. Every such new employee shall  
2424 provide a valid current social security number and/or driver's  
2425 license number which shall be furnished to the licensing agency or  
2426 to the private entity designated by the licensing agency to  
2427 conduct the criminal history record check. The institution for  
2428 the aged or infirm or care facility applying for the criminal  
2429 history record check will be promptly notified of any  
2430 disqualifying record found by the criminal history record check.  
2431 In order to determine the applicant's suitability for employment,  
2432 the applicant shall be fingerprinted. If no disqualifying record  
2433 is identified at the state level, the fingerprints shall be  
2434 forwarded by the Department of Public Safety to the Federal Bureau  
2435 of Investigation for a national criminal history record check.

2436 (b) A licensed institution for the aged or infirm or  
2437 care facility may make an offer of temporary employment to a  
2438 prospective employee pending the results of a criminal history  
2439 record check on the person. In such instances, the licensed  
2440 institution for the aged or infirm or care facility shall provide  
2441 to the licensing agency, or to the designated private entity, the  
2442 name and relevant information relating to the person within  
2443 seventy-two (72) hours after the date the person accepts temporary  
2444 employment.

2445 (c) All fees incurred in compliance with this section  
2446 shall be borne by the institution or facility requesting the  
2447 criminal history record check. The licensing agency, or the  
2448 designated private entity, is authorized to charge the institution  
2449 for the aged or infirm or care facility a fee which shall include  
2450 the amount required by the Mississippi Department of Public  
2451 Safety, the Federal Bureau of Investigation or any other agency  
2452 designated by the licensing agency for the national criminal  
2453 history record check in addition to any necessary costs incurred



2454 by the licensing agency or the designated private entity for the  
2455 handling and administration of the criminal history record checks.  
2456 Costs incurred by a nursing home provider implementing this act  
2457 shall be reimbursed as an allowable cost under Section 43-13-116.

2458 (d) The licensing agency, care facility, and their  
2459 agents, officers, employees, attorneys and representatives shall  
2460 be presumed to be acting in good faith for any employment decision  
2461 or action taken under paragraphs (a) and (b) of this subsection.  
2462 The presumption of good faith may be overcome by a preponderance  
2463 of the evidence in any civil action.

2464 (e) The licensing agency shall promulgate regulations  
2465 to implement this subsection (5).

2466 **SECTION 10.** Section 43-11-19, Mississippi Code of 1972, is  
2467 amended as follows:

2468 43-11-19. Information received or caused to be maintained or  
2469 collected by the licensing agency through filed reports,  
2470 inspection, or as otherwise authorized under this chapter, shall  
2471 not be disclosed by any person or party, except in a proceeding  
2472 involving the questions of licensure; however, the licensing  
2473 agency may utilize statistical data concerning types of services  
2474 and the utilization of those services for institutions for the  
2475 aged or infirm in performing the statutory duties imposed upon it  
2476 by Section 41-7-171, et seq. and by Section 43-11-21.

2477 **SECTION 11.** Section 41-63-21, Mississippi Code of 1972, is  
2478 amended as follows:

2479 41-63-21. The term "accreditation and quality assurance  
2480 materials" as used in Sections 41-63-21 through 41-63-29 means and  
2481 shall include written reports, records, correspondence and  
2482 materials concerning the accreditation or quality assurance of any  
2483 hospital, nursing home or other health care facility and any  
2484 medical care foundation, health maintenance organization,  
2485 preferred provider organization, individual practice association  
2486 or similar entity. \* \* \* The confidentiality established by



2487 Sections 41-63-21 through 41-63-29 shall apply to accreditation  
2488 and quality assurance materials prepared by an employee, advisor  
2489 or consultant of any hospital, nursing home or other health care  
2490 facility and any medical care foundation, health maintenance  
2491 organization, preferred provider organization, individual practice  
2492 association or similar entity and to materials provided by an  
2493 employee, advisor or consultant of an accreditation, quality  
2494 assurance or similar agency or similar body and to any individual  
2495 who is an employee, advisor or consultant of a hospital, nursing  
2496 home or other health care facility and any medical care  
2497 foundation, health maintenance organization, preferred provider  
2498 organization, individual practice association or similar entity or  
2499 accrediting, quality assurance or similar agency or body.

2500 **SECTION 12.** Section 43-7-53, Mississippi Code of 1972, is  
2501 amended as follows:

2502 43-7-53. (1) There is \* \* \* established within the  
2503 Mississippi Council on Aging, the Office of the State Long-Term  
2504 Care Facilities Ombudsman as provided by the Older Americans Act  
2505 of 1965, as amended, 42 USCS 3001.

2506 (2) The council shall establish the qualifications of state  
2507 and community ombudsmen. Those qualifications shall include  
2508 training and experience with long-term care facilities.

2509 **SECTION 13.** Section 43-7-61, Mississippi Code of 1972, is  
2510 amended as follows:

2511 43-7-61. (1) The Office of the State Long-Term Care  
2512 Facilities Ombudsman shall establish a training and certification  
2513 program. The council shall specify by rule the content of the  
2514 training program. Each long-term care facilities ombudsman  
2515 program shall bear the cost of training its own employees.

2516 (2) The State Ombudsman shall arrange for the training of  
2517 all prospective community ombudsmen selected by area agencies on  
2518 aging. Such training shall include instruction in at least the  
2519 following subjects as they relate to long-term care:



2520                   (a) The responsibilities and duties of community  
2521 ombudsmen;

2522                   (b) The laws and regulations governing the receipt,  
2523 investigation and resolution of issues of the well-being of a  
2524 resident;

2525                   (c) The role of local, state and federal agencies that  
2526 regulate long-term care facilities;

2527                   (d) The different kinds of long-term care facilities in  
2528 Mississippi and the services provided in each kind;

2529                   (e) The special needs of the elderly and of the  
2530 physically and mentally handicapped;

2531                   (f) The role of the family, the sponsor, the legal  
2532 representative, the physician, the church, and other public and  
2533 private agencies, and the community;

2534                   (g) How to work with long-term care facility staff;

2535                   (h) The aging process and characteristics of the  
2536 long-term care facility resident or institutionalized elderly;

2537                   (i) Familiarity with and access to information  
2538 concerning the laws and regulations governing Medicare, Medicaid,  
2539 Social Security, Supplemental Security Income, the Veterans  
2540 Administration and Workers' Compensation; and

2541                   (j) The training program shall include an appropriate  
2542 internship to be performed in a long-term care facility.

2543                   (3) Persons selected by area agencies on aging who have  
2544 satisfactorily completed the training arranged by the State  
2545 Ombudsman shall be certified as community ombudsmen by the  
2546 council.

2547                   (4) Each area agency on aging may appoint an advisory  
2548 committee to advise it in the operation of its community ombudsman  
2549 program. The number and qualifications of members of the advisory  
2550 committee shall be determined by the area agency on aging.

2551                   (5) Ombudsmen who have successfully completed the training  
2552 and certification program under this section shall be given



2553 identification cards which shall be presented to employees of a  
2554 long-term care facility upon request.

2555 (6) Ombudsmen shall participate in ongoing training programs  
2556 related to their duties and responsibilities.

2557 **SECTION 14.** This act shall take effect and be in force from  
2558 and after its passage.

