

By: Senator(s) Huggins

To: Public Health and
Welfare; AppropriationsSENATE BILL NO. 2189
(As Sent to Governor)

1 AN ACT TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
2 AS AMENDED BY HOUSE BILL NO. 1200 AND SENATE BILL NO. 3060, 2002
3 REGULAR SESSION, TO AUTHORIZE UNLIMITED DAY REIMBURSEMENT FOR
4 DISPROPORTIONATE SHARE PROGRAM HOSPITALS FOR ELIGIBLE CHILDREN
5 UNDER THE AGE OF SIX ONLY IF CERTIFIED AS MEDICALLY NECESSARY; TO
6 AUTHORIZE A JOINT LEGISLATIVE STUDY COMMITTEE TO CONSIDER THE
7 ISSUE OF SETTING UNIFORM REIMBURSEMENT RATES FOR NURSING HOMES; TO
8 DELETE SPECIFIC FEE INCREASES FOR PERIODIC SCREENING AND
9 DIAGNOSTIC SERVICES; TO DIRECT THE DIVISION TO ESTABLISH A CLOSED
10 DRUG FORMULARY; TO PROVIDE THAT THE MONTHLY LIMIT ON PRESCRIPTION
11 DRUGS DOES NOT APPLY TO INSTITUTIONALIZED RECIPIENTS; TO PROVIDE
12 THAT THE PRIOR APPROVAL REQUIREMENT FOR PRESCRIPTIONS ABOVE A
13 CERTAIN NUMBER APPLIES TO ALL RECIPIENTS; TO AUTHORIZE MEDICAID
14 REIMBURSEMENT FOR MENTAL HEALTH SERVICES PROVIDED IN THE COMMUNITY
15 BY A FACILITY OR PROGRAM OPERATED BY THE DEPARTMENT OF MENTAL
16 HEALTH; TO REVISE THE CONDITIONS FOR REIMBURSEMENT OF THE COST OF
17 EYEGASSES FOR RECIPIENTS; TO CLARIFY THE REQUIREMENT FOR
18 DISPROPORTIONATE SHARE PROGRAM HOSPITALS TO PARTICIPATE IN THE
19 FEDERAL INTERGOVERNMENTAL TRANSFER PROGRAM; TO AUTHORIZE THE
20 DIVISION OF MEDICAID TO ESTABLISH A MEDICARE UPPER PAYMENT LIMITS
21 PROGRAM FOR NURSING FACILITIES; TO CHANGE CERTAIN REFERENCES TO
22 THE FEDERAL INDIVIDUALS WITH DISABILITIES EDUCATION ACT; TO
23 AUTHORIZE MEDICAID REIMBURSEMENT TO RURAL HEALTH CENTERS FOR
24 AMBULATORY SERVICES; TO AUTHORIZE FUNDS TRANSFERRED TO THE
25 DEPARTMENT OF MENTAL HEALTH BY A POLITICAL SUBDIVISION OR
26 INSTRUMENTALITY OF THE STATE TO BE USED AS MEDICAID MATCH FOR
27 REIMBURSEMENT OF HOME- AND COMMUNITY-BASED SERVICES FOR
28 DEVELOPMENTALLY DISABLED PEOPLE; TO AUTHORIZE MEDICAID
29 REIMBURSEMENT TO CHIROPRACTORS FOR X-RAYS PERFORMED TO DOCUMENT
30 CONDITIONS; TO AUTHORIZE THE DIVISION TO APPLY FOR FEDERAL WAIVERS
31 THAT MAY ENHANCE THE POPULATION HEALTH MANAGEMENT PROGRAM; TO
32 PROVIDE MEDICAID REIMBURSEMENT FOR PEDIATRIC LONG-TERM ACUTE CARE
33 HOSPITAL SERVICES; TO EXEMPT NONEMERGENCY TRANSPORTATION SERVICES
34 FROM THE REQUIREMENT FOR A COPAYMENT; TO PROVIDE THAT THE FIVE
35 PERCENT REDUCTION IN PROVIDER REIMBURSEMENTS IMPOSED BY HOUSE BILL
36 NO. 1200, 2002 REGULAR SESSION, SHALL NOT APPLY TO THOSE HEALTH
37 CARE FACILITIES UPON WHICH AN ASSESSMENT IS LEVIED UNDER SECTION
38 43-13-145, MISSISSIPPI CODE OF 1972; TO PROVIDE THAT THE FIVE
39 PERCENT REDUCTION ALSO SHALL NOT APPLY TO CERTAIN SERVICES
40 PROVIDED BY PLANNING AND DEVELOPMENT DISTRICTS IF THE DISTRICTS
41 TRANSFER CERTAIN SUMS TO THE DIVISION; TO AMEND SECTION 43-13-121,
42 MISSISSIPPI CODE OF 1972, TO CLARIFY AND REVISE THE CONDITIONS FOR
43 DENYING OR REVOKING PROVIDER ENROLLMENT IN THE MEDICAID PROGRAM;
44 TO AMEND SECTION 43-13-123, MISSISSIPPI CODE OF 1972, TO CLARIFY
45 THAT THE DIVISION SHALL OBTAIN SERVICES IN ACCORDANCE WITH
46 REGULATIONS OF THE PERSONAL SERVICE CONTRACT REVIEW BOARD; TO
47 AMEND SECTION 43-13-127, MISSISSIPPI CODE OF 1972, TO REQUIRE THE
48 DIVISION OF MEDICAID TO SUBMIT A MONTHLY REPORT TO THE CHAIRMEN OF
49 THE SENATE AND HOUSE PUBLIC HEALTH AND WELFARE COMMITTEES AND TO
50 THE JOINT LEGISLATIVE BUDGET COMMITTEE; TO AMEND SECTION
51 43-13-145, MISSISSIPPI CODE OF 1972, TO INCREASE THE MEDICAID
52 ASSESSMENT ON NURSING HOME BEDS AND PROVIDE FOR MEDICAID



53 ASSESSMENTS ON OTHER HEALTH CARE FACILITIES; TO PROVIDE FOR THE
54 COLLECTION OF THOSE ASSESSMENTS; TO AMEND SECTION 41-7-191,
55 MISSISSIPPI CODE OF 1972, TO PROVIDE THAT THE ADDITION OR
56 CONVERSION OF ANY NUMBER OF BEDS OF A HEALTH CARE FACILITY SHALL
57 REQUIRE APPROVAL BY A CERTIFICATE OF NEED; TO DIRECT THE STATE
58 DEPARTMENT OF HEALTH TO TRANSFER A CERTAIN CERTIFICATE OF NEED
59 AUTHORIZING PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY BEDS IN
60 WARREN COUNTY; AND FOR RELATED PURPOSES.

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

62 **SECTION 1.** Section 43-13-117, Mississippi Code of 1972, as
63 amended by House Bill No. 1200 and Senate Bill No. 3060, 2002
64 Regular Session, is amended as follows:

65 43-13-117. Medicaid as authorized by this article shall
66 include payment of part or all of the costs, at the discretion of
67 the division or its successor, with approval of the Governor, of
68 the following types of care and services rendered to eligible
69 applicants who have been determined to be eligible for that care
70 and services, within the limits of state appropriations and
71 federal matching funds:

72 (1) Inpatient hospital services.

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

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

86 (c) Hospitals will receive an additional payment
87 for the implantable programmable baclofen drug pump used to treat
88 spasticity which is implanted on an inpatient basis. The payment
89 pursuant to written invoice will be in addition to the facility's



90 per diem reimbursement and will represent a reduction of costs on
91 the facility's annual cost report, and shall not exceed Ten
92 Thousand Dollars (\$10,000.00) per year per recipient. This
93 paragraph (c) shall stand repealed on July 1, 2005.

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

98 (3) Laboratory and x-ray services.

99 (4) Nursing facility services.

100 (a) The division shall make full payment to
101 nursing facilities for each day, not exceeding fifty-two (52) days
102 per year, that a patient is absent from the facility on home
103 leave. Payment may be made for the following home leave days in
104 addition to the fifty-two-day limitation: Christmas, the day
105 before Christmas, the day after Christmas, Thanksgiving, the day
106 before Thanksgiving and the day after Thanksgiving.

107 (b) From and after July 1, 1997, the division
108 shall implement the integrated case-mix payment and quality
109 monitoring system, which includes the fair rental system for
110 property costs and in which recapture of depreciation is
111 eliminated. The division may reduce the payment for hospital
112 leave and therapeutic home leave days to the lower of the case-mix
113 category as computed for the resident on leave using the
114 assessment being utilized for payment at that point in time, or a
115 case-mix score of 1.000 for nursing facilities, and shall compute
116 case-mix scores of residents so that only services provided at the
117 nursing facility are considered in calculating a facility's per
118 diem.

119 During the period between May 1, 2002, and December 1, 2002,
120 the Chairmen of the Public Health and Welfare Committees of the
121 Senate and the House of Representatives may appoint a joint study
122 committee to consider the issue of setting uniform reimbursement



123 rates for nursing facilities. The study committee will consist of
124 the Chairmen of the Public Health and Welfare Committees, three
125 (3) members of the Senate and three (3) members of the House. The
126 study committee shall complete its work in not more than three (3)
127 meetings.

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

131 (d) When a facility of a category that does not
132 require a certificate of need for construction and that could not
133 be eligible for Medicaid reimbursement is constructed to nursing
134 facility specifications for licensure and certification, and the
135 facility is subsequently converted to a nursing facility under a
136 certificate of need that authorizes conversion only and the
137 applicant for the certificate of need was assessed an application
138 review fee based on capital expenditures incurred in constructing
139 the facility, the division shall allow reimbursement for capital
140 expenditures necessary for construction of the facility that were
141 incurred within the twenty-four (24) consecutive calendar months
142 immediately preceding the date that the certificate of need
143 authorizing the conversion was issued, to the same extent that
144 reimbursement would be allowed for construction of a new nursing
145 facility under a certificate of need that authorizes that
146 construction. The reimbursement authorized in this subparagraph
147 (d) may be made only to facilities the construction of which was
148 completed after June 30, 1989. Before the division shall be
149 authorized to make the reimbursement authorized in this
150 subparagraph (d), the division first must have received approval
151 from the Health Care Financing Administration of the United States
152 Department of Health and Human Services of the change in the state
153 Medicaid plan providing for the reimbursement.

154 (e) The division shall develop and implement, not
155 later than January 1, 2001, a case-mix payment add-on determined



156 by time studies and other valid statistical data that will
157 reimburse a nursing facility for the additional cost of caring for
158 a resident who has a diagnosis of Alzheimer's or other related
159 dementia and exhibits symptoms that require special care. Any
160 such case-mix add-on payment shall be supported by a determination
161 of additional cost. The division shall also develop and implement
162 as part of the fair rental reimbursement system for nursing
163 facility beds, an Alzheimer's resident bed depreciation enhanced
164 reimbursement system that will provide an incentive to encourage
165 nursing facilities to convert or construct beds for residents with
166 Alzheimer's or other related dementia.

167 (f) The Division of Medicaid shall develop and
168 implement a referral process for long-term care alternatives for
169 Medicaid beneficiaries and applicants. No Medicaid beneficiary
170 shall be admitted to a Medicaid-certified nursing facility unless
171 a licensed physician certifies that nursing facility care is
172 appropriate for that person on a standardized form to be prepared
173 and provided to nursing facilities by the Division of Medicaid.
174 The physician shall forward a copy of that certification to the
175 Division of Medicaid within twenty-four (24) hours after it is
176 signed by the physician. Any physician who fails to forward the
177 certification to the Division of Medicaid within the time period
178 specified in this paragraph shall be ineligible for Medicaid
179 reimbursement for any physician's services performed for the
180 applicant. The Division of Medicaid shall determine, through an
181 assessment of the applicant conducted within two (2) business days
182 after receipt of the physician's certification, whether the
183 applicant also could live appropriately and cost-effectively at
184 home or in some other community-based setting if home- or
185 community-based services were available to the applicant. The
186 time limitation prescribed in this paragraph shall be waived in
187 cases of emergency. If the Division of Medicaid determines that a



188 home- or other community-based setting is appropriate and
189 cost-effective, the division shall:

190 (i) Advise the applicant or the applicant's
191 legal representative that a home- or other community-based setting
192 is appropriate;

193 (ii) Provide a proposed care plan and inform
194 the applicant or the applicant's legal representative regarding
195 the degree to which the services in the care plan are available in
196 a home- or in other community-based setting rather than nursing
197 facility care; and

198 (iii) Explain that the plan and services are
199 available only if the applicant or the applicant's legal
200 representative chooses a home- or community-based alternative to
201 nursing facility care, and that the applicant is free to choose
202 nursing facility care.

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

208 Placement in a nursing facility may not be denied by the
209 division if home- or community-based services that would be more
210 appropriate than nursing facility care are not actually available,
211 or if the applicant chooses not to receive the appropriate home-
212 or community-based services.

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

217 The division shall make full payment for long-term care
218 alternative services.

219 The division shall apply for necessary federal waivers to
220 assure that additional services providing alternatives to nursing



221 facility care are made available to applicants for nursing
222 facility care.

223 (5) Periodic screening and diagnostic services for
224 individuals under age twenty-one (21) years as are needed to
225 identify physical and mental defects and to provide health care
226 treatment and other measures designed to correct or ameliorate
227 defects and physical and mental illness and conditions discovered
228 by the screening services regardless of whether these services are
229 included in the state plan. The division may include in its
230 periodic screening and diagnostic program those discretionary
231 services authorized under the federal regulations adopted to
232 implement Title XIX of the federal Social Security Act, as
233 amended. The division, in obtaining physical therapy services,
234 occupational therapy services, and services for individuals with
235 speech, hearing and language disorders, may enter into a
236 cooperative agreement with the State Department of Education for
237 the provision of those services to handicapped students by public
238 school districts using state funds that are provided from the
239 appropriation to the Department of Education to obtain federal
240 matching funds through the division. The division, in obtaining
241 medical and psychological evaluations for children in the custody
242 of the State Department of Human Services may enter into a
243 cooperative agreement with the State Department of Human Services
244 for the provision of those services using state funds that are
245 provided from the appropriation to the Department of Human
246 Services to obtain federal matching funds through the division.

247 * * *

248 (6) Physician's services. The division shall allow
249 twelve (12) physician visits annually. All fees for physicians'
250 services that are covered only by Medicaid shall be reimbursed at
251 ninety percent (90%) of the rate established on January 1, 1999,
252 and as adjusted each January thereafter, under Medicare (Title
253 XVIII of the Social Security Act, as amended), and which shall in



254 no event be less than seventy percent (70%) of the rate
255 established on January 1, 1994. All fees for physicians' services
256 that are covered by both Medicare and Medicaid shall be reimbursed
257 at ten percent (10%) of the adjusted Medicare payment established
258 on January 1, 1999, and as adjusted each January thereafter, under
259 Medicare (Title XVIII of the Social Security Act, as amended), and
260 which shall in no event be less than seventy percent (70%) of the
261 adjusted Medicare payment established on January 1, 1994.

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

266 (b) Repealed.

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

278 (9) (a) Legend and other drugs as may be determined by
279 the division. The division shall opt out of the federal drug
280 rebate program and shall create a closed drug formulary as soon as
281 practicable after the effective date of Senate Bill No. 2189, 2002
282 Regular Session. Drugs included on the formulary will be those
283 with the lowest and best price as determined through a bidding
284 process. The division may implement a program of prior approval
285 for drugs to the extent permitted by law. The division shall
286 allow seven (7) prescriptions per month for each



287 noninstitutionalized Medicaid recipient; however, after a
288 noninstitutionalized or institutionalized recipient has received
289 five (5) prescriptions in any month, each additional prescription
290 during that month must have the prior approval of the division.
291 The division shall not reimburse for any portion of a prescription
292 that exceeds a thirty-four-day supply of the drug based on the
293 daily dosage.

294 The dispensing fee for each new or refill prescription shall
295 be Three Dollars and Ninety-one Cents (\$3.91).

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

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

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

309 (b) Legend and other drugs as may be determined by
310 the division. The division may implement a program of prior
311 approval for drugs to the extent permitted by law. Payment by the
312 division for covered multiple source drugs shall be limited to the
313 lower of the upper limits established and published by the Centers
314 for Medicare and Medicaid Services (CMS) plus a dispensing fee, or
315 the estimated acquisition cost (EAC) plus a dispensing fee, or the
316 providers' usual and customary charge to the general public. The
317 division shall allow seven (7) prescriptions per month for each
318 noninstitutionalized Medicaid recipient; however, after a
319 noninstitutionalized or institutionalized recipient has received



320 five (5) prescriptions in any month, each additional prescription
321 during that month must have the prior approval of the division.
322 The division shall not reimburse for any portion of a prescription
323 that exceeds a thirty-four-day supply of the drug based on the
324 daily dosage.

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

329 Payment for nonlegend or over-the-counter drugs covered on
330 the division's formulary shall be reimbursed at the lower of the
331 division's estimated shelf price or the providers' usual and
332 customary charge to the general public. No dispensing fee shall
333 be paid.

334 The dispensing fee for each new or refill prescription shall
335 be Three Dollars and Ninety-one Cents (\$3.91).

336 The Medicaid provider shall not prescribe, the Medicaid
337 pharmacy shall not bill, and the division shall not reimburse for
338 name brand drugs if there are equally effective generic
339 equivalents available and if the generic equivalents are the least
340 expensive.

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

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

349 The division shall develop a pharmacy policy in which drugs
350 in tamper-resistant packaging that are prescribed for a resident
351 of a nursing facility but are not dispensed to the resident shall



352 be returned to the pharmacy and not billed to Medicaid, in
353 accordance with guidelines of the State Board of Pharmacy.

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

357 (c) The division may operate the drug program
358 under the provisions of subparagraph (b) until the closed drug
359 formulary required by subparagraph (a) is established and
360 implemented. Subparagraph (a) of this paragraph (9) shall stand
361 repealed on July 1, 2003.

362 (10) Dental care that is an adjunct to treatment of an
363 acute medical or surgical condition; services of oral surgeons and
364 dentists in connection with surgery related to the jaw or any
365 structure contiguous to the jaw or the reduction of any fracture
366 of the jaw or any facial bone; and emergency dental extractions
367 and treatment related thereto. On July 1, 1999, all fees for
368 dental care and surgery under authority of this paragraph (10)
369 shall be increased to one hundred sixty percent (160%) of the
370 amount of the reimbursement rate that was in effect on June 30,
371 1999. It is the intent of the Legislature to encourage more
372 dentists to participate in the Medicaid program.

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

382 (12) Intermediate care facility services.

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



385 day, not exceeding eighty-four (84) days per year, that a patient
386 is absent from the facility on home leave. Payment may be made
387 for the following home leave days in addition to the
388 eighty-four-day limitation: Christmas, the day before Christmas,
389 the day after Christmas, Thanksgiving, the day before Thanksgiving
390 and the day after Thanksgiving.

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

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

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



418 1, 1999, all fees for dentists' services reimbursed under
419 authority of this paragraph (14) shall be increased to one hundred
420 sixty percent (160%) of the amount of the reimbursement rate that
421 was in effect on June 30, 1999.

422 (15) Home- and community-based services, as provided
423 under Title XIX of the federal Social Security Act, as amended,
424 under waivers, subject to the availability of funds specifically
425 appropriated therefor by the Legislature * * *. Payment for those
426 services shall be limited to individuals who would be eligible for
427 and would otherwise require the level of care provided in a
428 nursing facility. The home- and community-based services
429 authorized under this paragraph shall be expanded over a five-year
430 period beginning July 1, 1999. The division shall certify case
431 management agencies to provide case management services and
432 provide for home- and community-based services for eligible
433 individuals under this paragraph. The home- and community-based
434 services under this paragraph and the activities performed by
435 certified case management agencies under this paragraph shall be
436 funded using state funds that are provided from the appropriation
437 to the Division of Medicaid * * * and used to match federal funds.

438 (16) Mental health services. Approved therapeutic and
439 case management services (a) provided by * * * an approved
440 regional mental health/retardation center established under
441 Sections 41-19-31 through 41-19-39, or by another community mental
442 health service provider meeting the requirements of the Department
443 of Mental Health to be an approved mental health/retardation
444 center if determined necessary by the Department of Mental Health,
445 using state funds that are provided from the appropriation to the
446 State Department of Mental Health and/or funds transferred to the
447 department by a political subdivision or instrumentality of the
448 state and used to match federal funds under a cooperative
449 agreement between the division and the department, or (b) provided
450 by a facility that is certified by the State Department of Mental



451 Health to provide therapeutic and case management services, to be
452 reimbursed on a fee for service basis, or (c) provided in the
453 community by a facility or program operated by the Department of
454 Mental Health. Any such services provided by a facility described
455 in paragraph (b) must have the prior approval of the division to
456 be reimbursable under this section. After June 30, 1997, mental
457 health services provided by regional mental health/retardation
458 centers established under Sections 41-19-31 through 41-19-39, or
459 by hospitals as defined in Section 41-9-3(a) and/or their
460 subsidiaries and divisions, or by psychiatric residential
461 treatment facilities as defined in Section 43-11-1, or by another
462 community mental health service provider meeting the requirements
463 of the Department of Mental Health to be an approved mental
464 health/retardation center if determined necessary by the
465 Department of Mental Health, shall not be included in or provided
466 under any capitated managed care pilot program provided for under
467 paragraph (24) of this section.

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

474 (18) (a) Notwithstanding any other provision of this
475 section to the contrary, the division shall make additional
476 reimbursement to hospitals that serve a disproportionate share of
477 low-income patients and that meet the federal requirements for
478 those payments as provided in Section 1923 of the federal Social
479 Security Act and any applicable regulations. However, from and
480 after January 1, 1999, no public hospital shall participate in the
481 Medicaid disproportionate share program unless the public hospital
482 participates in an intergovernmental transfer program as provided
483 in Section 1903 of the federal Social Security Act and any



484 applicable regulations. Administration and support for
485 participating hospitals shall be provided by the Mississippi
486 Hospital Association.

487 (b) The division shall establish a Medicare Upper
488 Payment Limits Program, as defined in Section 1902(a)(30) of the
489 federal Social Security Act and any applicable federal
490 regulations, for hospitals, and may establish a Medicare Upper
491 Payments Limits Program for nursing facilities. The division
492 shall assess each hospital and, if the program is established for
493 nursing facilities, shall assess each nursing facility, for the
494 sole purpose of financing the state portion of the Medicare Upper
495 Payment Limits Program. This assessment shall be based on
496 Medicaid utilization, or other appropriate method consistent with
497 federal regulations, and will remain in effect as long as the
498 state participates in the Medicare Upper Payment Limits Program.
499 The division shall make additional reimbursement to hospitals and,
500 if the program is established for nursing facilities, shall make
501 additional reimbursement to nursing facilities, for the Medicare
502 Upper Payment Limits, as defined in Section 1902(a)(30) of the
503 federal Social Security Act and any applicable federal
504 regulations. This paragraph (b) shall stand repealed from and
505 after July 1, 2005.

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

511 (19) (a) Perinatal risk management services. The
512 division shall promulgate regulations to be effective from and
513 after October 1, 1988, to establish a comprehensive perinatal
514 system for risk assessment of all pregnant and infant Medicaid
515 recipients and for management, education and follow-up for those
516 who are determined to be at risk. Services to be performed



517 include case management, nutrition assessment/counseling,
518 psychosocial assessment/counseling and health education. The
519 division shall set reimbursement rates for providers in
520 conjunction with the State Department of Health.

521 (b) Early intervention system services. The
522 division shall cooperate with the State Department of Health,
523 acting as lead agency, in the development and implementation of a
524 statewide system of delivery of early intervention services, under
525 Part C of the Individuals with Disabilities Education Act (IDEA).
526 The State Department of Health shall certify annually in writing
527 to the executive director of the division the dollar amount of
528 state early intervention funds available that will be utilized as
529 a certified match for Medicaid matching funds. Those funds then
530 shall be used to provide expanded targeted case management
531 services for Medicaid eligible children with special needs who are
532 eligible for the state's early intervention system.
533 Qualifications for persons providing service coordination shall be
534 determined by the State Department of Health and the Division of
535 Medicaid.

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

546 (21) Nurse practitioner services. Services furnished
547 by a registered nurse who is licensed and certified by the
548 Mississippi Board of Nursing as a nurse practitioner, including,
549 but not limited to, nurse anesthetists, nurse midwives, family



550 nurse practitioners, family planning nurse practitioners,
551 pediatric nurse practitioners, obstetrics-gynecology nurse
552 practitioners and neonatal nurse practitioners, under regulations
553 adopted by the division. Reimbursement for those services shall
554 not exceed ninety percent (90%) of the reimbursement rate for
555 comparable services rendered by a physician.

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

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

573 (24) [Deleted]

574 (25) Birthing center services.

575 (26) Hospice care. As used in this paragraph, the term
576 "hospice care" means a coordinated program of active professional
577 medical attention within the home and outpatient and inpatient
578 care that treats the terminally ill patient and family as a unit,
579 employing a medically directed interdisciplinary team. The
580 program provides relief of severe pain or other physical symptoms
581 and supportive care to meet the special needs arising out of
582 physical, psychological, spiritual, social and economic stresses



583 that are experienced during the final stages of illness and during
584 dying and bereavement and meets the Medicare requirements for
585 participation as a hospice as provided in federal regulations.

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

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

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

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

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

612 (32) Care and services provided in Christian Science
613 Sanatoria listed and certified by the Commission for Accreditation
614 of Christian Science Nursing Organizations/Facilities, Inc.,
615 rendered in connection with treatment by prayer or spiritual means



616 to the extent that those services are subject to reimbursement
617 under Section 1903 of the Social Security Act.

618 (33) Podiatrist services.

619 (34) The division shall make application to the United
620 States Health Care Financing Administration for a waiver to
621 develop a program of services to personal care and assisted living
622 homes in Mississippi. This waiver shall be completed by December
623 1, 1999.

624 (35) Services and activities authorized in Sections
625 43-27-101 and 43-27-103, using state funds that are provided from
626 the appropriation to the State Department of Human Services and
627 used to match federal funds under a cooperative agreement between
628 the division and the department.

629 (36) Nonemergency transportation services for
630 Medicaid-eligible persons, to be provided by the Division of
631 Medicaid. The division may contract with additional entities to
632 administer nonemergency transportation services as it deems
633 necessary. All providers shall have a valid driver's license,
634 vehicle inspection sticker, valid vehicle license tags and a
635 standard liability insurance policy covering the vehicle.

636 (37) [Deleted]

637 (38) Chiropractic services. A chiropractor's manual
638 manipulation of the spine to correct a subluxation, if x-ray
639 demonstrates that a subluxation exists and if the subluxation has
640 resulted in a neuromusculoskeletal condition for which
641 manipulation is appropriate treatment, and related spinal x-rays
642 performed to document these conditions. Reimbursement for
643 chiropractic services shall not exceed Seven Hundred Dollars
644 (\$700.00) per year per beneficiary.

645 (39) Dually eligible Medicare/Medicaid beneficiaries.
646 The division shall pay the Medicare deductible and ten percent
647 (10%) coinsurance amounts for services available under Medicare



648 for the duration and scope of services otherwise available under
649 the Medicaid program.

650 (40) [Deleted]

651 (41) Services provided by the State Department of
652 Rehabilitation Services for the care and rehabilitation of persons
653 with spinal cord injuries or traumatic brain injuries, as allowed
654 under waivers from the United States Department of Health and
655 Human Services, using up to seventy-five percent (75%) of the
656 funds that are appropriated to the Department of Rehabilitation
657 Services from the Spinal Cord and Head Injury Trust Fund
658 established under Section 37-33-261 and used to match federal
659 funds under a cooperative agreement between the division and the
660 department.

661 (42) Notwithstanding any other provision in this
662 article to the contrary, the division may develop a population
663 health management program for women and children health services
664 through the age of two (2) years. This program is primarily for
665 obstetrical care associated with low birth weight and pre-term
666 babies. The division may apply to the federal Centers for
667 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
668 any other waivers that may enhance the program. In order to
669 effect cost savings, the division may develop a revised payment
670 methodology that may include at-risk capitated payments, and may
671 require member participation in accordance with the terms and
672 conditions of an approved federal waiver.

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

678 (44) Nursing facility services for the severely
679 disabled.



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

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

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

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

705 (47) Notwithstanding any other provision in this
706 article to the contrary, the division, in conjunction with the
707 State Department of Health, shall develop and implement disease
708 management programs statewide for individuals with asthma,
709 diabetes or hypertension, including the use of grants, waivers,
710 demonstrations or other projects as necessary.

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



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

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

721 (49) The division shall establish copayments for all
722 Medicaid services for which copayments are allowable under federal
723 law or regulation, except for nonemergency transportation
724 services, and shall set the amount of the copayment for each of
725 those services at the maximum amount allowable under federal law
726 or regulation.

727 Notwithstanding any other provision of this article to the
728 contrary, the division shall reduce the rate of reimbursement to
729 providers for any service provided under this section by five
730 percent (5%) of the allowed amount for that service. However, the
731 reduction in the reimbursement rates required by this paragraph
732 shall not apply to inpatient hospital services, nursing facility
733 services, intermediate care facility services, psychiatric
734 residential treatment facility services, pharmacy services
735 provided under paragraph (9) of this section, or any service
736 provided by the University of Mississippi Medical Center or a
737 state agency, a state facility or a public agency that either
738 provides its own state match through intergovernmental transfer or
739 certification of funds to the division, or a service for which the
740 federal government sets the reimbursement methodology and rate.
741 In addition, the reduction in the reimbursement rates required by
742 this paragraph shall not apply to case management services and
743 home delivered meal services provided under the home- and
744 community-based services program for the elderly and disabled by a



745 planning and development district, if the planning and development
746 district transfers to the division a sum equal to the amount of
747 the reduction in reimbursement that would otherwise be made for
748 those services under this paragraph.

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

765 Notwithstanding any provision of this article, no new groups
766 or categories of recipients and new types of care and services may
767 be added without enabling legislation from the Mississippi
768 Legislature, except that the division may authorize those changes
769 without enabling legislation when the addition of recipients or
770 services is ordered by a court of proper authority. The executive
771 director shall keep the Governor advised on a timely basis of the
772 funds available for expenditure and the projected expenditures.
773 If current or projected expenditures of the division can be
774 reasonably anticipated to exceed the amounts appropriated for any
775 fiscal year, the Governor, after consultation with the executive
776 director, shall discontinue any or all of the payment of the types
777 of care and services as provided in this section that are deemed



778 to be optional services under Title XIX of the federal Social
779 Security Act, as amended, for any period necessary to not exceed
780 appropriated funds, and when necessary shall institute any other
781 cost containment measures on any program or programs authorized
782 under the article to the extent allowed under the federal law
783 governing that program or programs, it being the intent of the
784 Legislature that expenditures during any fiscal year shall not
785 exceed the amounts appropriated for that fiscal year.

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

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

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

800 43-13-121. (1) The division shall administer the Medicaid
801 program * * * under the provisions of this article, and may do the
802 following:

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

806 (i) Establishing methods and procedures as may be
807 necessary for the proper and efficient administration of this
808 article;



809 (ii) Providing Medicaid to all qualified
810 recipients under the provisions of this article as the division
811 may determine and within the limits of appropriated funds;

812 (iii) Establishing reasonable fees, charges and
813 rates for medical services and drugs; * * * in doing so, the
814 division shall fix all of those fees, charges and rates at the
815 minimum levels absolutely necessary to provide the medical
816 assistance authorized by this article, and shall not change any of
817 those fees, charges or rates except as may be authorized in
818 Section 43-13-117;

819 (iv) Providing for fair and impartial hearings;

820 (v) Providing safeguards for preserving the
821 confidentiality of records; and

822 (vi) For detecting and processing fraudulent
823 practices and abuses of the program;

824 (b) Receive and expend state, federal and other funds
825 in accordance with court judgments or settlements and agreements
826 between the State of Mississippi and the federal government, the
827 rules and regulations promulgated by the division, with the
828 approval of the Governor, and within the limitations and
829 restrictions of this article and within the limits of funds
830 available for that purpose;

831 (c) Subject to the limits imposed by this article, to
832 submit a Medicaid plan * * * to the federal Department of Health
833 and Human Services for approval under the provisions of the Social
834 Security Act, to act for the state in making negotiations relative
835 to the submission and approval of that plan, to make such
836 arrangements, not inconsistent with the law, as may be required by
837 or under federal law to obtain and retain that approval and to
838 secure for the state the benefits of the provisions of that law.

839 No agreements, specifically including the general plan for
840 the operation of the Medicaid program in this state, shall be made
841 by and between the division and the Department of Health and Human



842 Services unless the Attorney General of the State of Mississippi
843 has reviewed the agreements, specifically including the
844 operational plan, and has certified in writing to the Governor and
845 to the executive director of the division that the agreements,
846 including the plan of operation, have been drawn strictly in
847 accordance with the terms and requirements of this article;

848 (d) In accordance with the purposes and intent of this
849 article and in compliance with its provisions, provide for aged
850 persons otherwise eligible for the benefits provided under Title
851 XVIII of the federal Social Security Act by expenditure of funds
852 available for those purposes;

853 (e) To make reports to the federal Department of Health
854 and Human Services as from time to time may be required by that
855 federal department and to the Mississippi Legislature as * * *
856 provided in this section;

857 (f) Define and determine the scope, duration and amount
858 of Medicaid that may be provided in accordance with this article
859 and establish priorities therefor in conformity with this article;

860 (g) Cooperate and contract with other state agencies
861 for the purpose of coordinating Medicaid provided under this
862 article and eliminating duplication and inefficiency in the
863 Medicaid program;

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

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

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

871 (k) To recover any and all payments by the division or
872 by the Medicaid Commission fraudulently obtained by a recipient or
873 provider. Additionally, if recovery of any payments fraudulently
874 obtained by a recipient or provider is made in any court, then,



875 upon motion of the Governor, the judge of the court may award
876 twice the payments recovered as damages;

877 (1) Have full, complete and plenary power and authority
878 to conduct such investigations as it may deem necessary and
879 requisite of alleged or suspected violations or abuses of the
880 provisions of this article or of the regulations adopted under
881 this article, including, but not limited to, fraudulent or
882 unlawful act or deed by applicants for Medicaid or other benefits,
883 or payments made to any person, firm or corporation under the
884 terms, conditions and authority of this article, to suspend or
885 disqualify any provider of services, applicant or recipient for
886 gross abuse, fraudulent or unlawful acts for such periods,
887 including permanently, and under such conditions as the
888 division * * * deems proper and just, including the imposition of
889 a legal rate of interest on the amount improperly or incorrectly
890 paid. Recipients who are found to have misused or abused Medicaid
891 benefits may be locked into one (1) physician and/or one (1)
892 pharmacy of the recipient's choice for a reasonable amount of time
893 in order to educate and promote appropriate use of medical
894 services, in accordance with federal regulations. If an
895 administrative hearing becomes necessary, the division may, if the
896 provider does not succeed in his defense, tax the costs of the
897 administrative hearing, including the costs of the court reporter
898 or stenographer and transcript, to the provider. The convictions
899 of a recipient or a provider in a state or federal court for
900 abuse, fraudulent or unlawful acts under this chapter shall
901 constitute an automatic disqualification of the recipient or
902 automatic disqualification of the provider from participation
903 under the Medicaid program.

904 A conviction, for the purposes of this chapter, shall include
905 a judgment entered on a plea of nolo contendere or a
906 nonadjudicated guilty plea and shall have the same force as a
907 judgment entered pursuant to a guilty plea or a conviction



908 following trial. A certified copy of the judgment of the court of
909 competent jurisdiction of the conviction shall constitute prima
910 facie evidence of the conviction for disqualification purposes;

911 (m) Establish and provide such methods of
912 administration as may be necessary for the proper and efficient
913 operation of the Medicaid program, fully utilizing computer
914 equipment as may be necessary to oversee and control all current
915 expenditures for purposes of this article, and to closely monitor
916 and supervise all recipient payments and vendors rendering * * *
917 services under this article;

918 (n) To cooperate and contract with the federal
919 government for the purpose of providing Medicaid to Vietnamese and
920 Cambodian refugees, under the provisions of Public Law 94-23 and
921 Public Law 94-24, including any amendments to those laws, only to
922 the extent that the Medicaid assistance and the administrative
923 cost related thereto are one hundred percent (100%) reimbursable
924 by the federal government. For the purposes of Section 43-13-117,
925 persons receiving Medicaid under Public Law 94-23 and Public Law
926 94-24, including any amendments to those laws, shall not be
927 considered a new group or category of recipient; and

928 (o) The division shall impose penalties upon Medicaid
929 only, Title XIX participating long-term care facilities found to
930 be in noncompliance with division and certification standards in
931 accordance with federal and state regulations, including interest
932 at the same rate calculated by the Department of Health and Human
933 Services and/or the Centers for Medicare and Medicaid Services
934 (CMS) under federal regulations.

935 (2) The division also shall exercise such additional powers
936 and perform such other duties as may be conferred upon the
937 division by act of the Legislature * * *.

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



941 contract for or otherwise provide for the consolidation of on-site
942 inspections of health care facilities that are necessitated by the
943 respective programs and functions of the division and the
944 department.

945 (4) The division and its hearing officers shall have power
946 to preserve and enforce order during hearings; to issue subpoenas
947 for, to administer oaths to and to compel the attendance and
948 testimony of witnesses, or the production of books, papers,
949 documents and other evidence, or the taking of depositions before
950 any designated individual competent to administer oaths; to
951 examine witnesses; and to do all things conformable to law that
952 may be necessary to enable them effectively to discharge the
953 duties of their office. In compelling the attendance and
954 testimony of witnesses, or the production of books, papers,
955 documents and other evidence, or the taking of depositions, as
956 authorized by this section, the division or its hearing officers
957 may designate an individual employed by the division or some other
958 suitable person to execute and return that process, whose action
959 in executing and returning that process shall be as lawful as if
960 done by the sheriff or some other proper officer authorized to
961 execute and return process in the county where the witness may
962 reside. In carrying out the investigatory powers under the
963 provisions of this article, the executive director or other
964 designated person or persons may examine, obtain, copy or
965 reproduce the books, papers, documents, medical charts,
966 prescriptions and other records relating to medical care and
967 services furnished by the provider to a recipient or designated
968 recipients of Medicaid services under investigation. In the
969 absence of the voluntary submission of the books, papers,
970 documents, medical charts, prescriptions and other records, the
971 Governor, the executive director, or other designated person may
972 issue and serve subpoenas instantly upon the provider, his agent,
973 servant or employee for the production of the books, papers,



974 documents, medical charts, prescriptions or other records during
975 an audit or investigation of the provider. If any provider or his
976 agent, servant or employee * * * refuses to produce the records
977 after being duly subpoenaed, the executive director may certify
978 those facts and institute contempt proceedings in the manner, time
979 and place as authorized by law for administrative proceedings. As
980 an additional remedy, the division may recover all amounts paid to
981 the provider covering the period of the audit or investigation,
982 inclusive of a legal rate of interest and a reasonable attorney's
983 fee and costs of court if suit becomes necessary. Division staff
984 shall have immediate access to the provider's physical location,
985 facilities, records, documents, books, and any other records
986 relating to medical care and services rendered to recipients
987 during regular business hours.

988 (5) If any person in proceedings before the division
989 disobeys or resists any lawful order or process, or misbehaves
990 during a hearing or so near the place thereof as to obstruct the
991 same, or neglects to produce, after having been ordered to do so,
992 any pertinent book, paper or document, or refuses to appear after
993 having been subpoenaed, or upon appearing refuses to take the oath
994 as a witness, or after having taken the oath refuses to be
995 examined according to law, the executive director shall certify
996 the facts to any court having jurisdiction in the place in which
997 it is sitting, and the court shall thereupon, in a summary manner,
998 hear the evidence as to the acts complained of, and if the
999 evidence so warrants, punish that person in the same manner and to
1000 the same extent as for a contempt committed before the court, or
1001 commit that person upon the same condition as if the doing of the
1002 forbidden act had occurred with reference to the process of, or in
1003 the presence of, the court.

1004 (6) In suspending or terminating any provider from
1005 participation in the Medicaid program, the division shall preclude
1006 the provider from submitting claims for payment, either personally



1007 or through any clinic, group, corporation or other association to
1008 the division or its fiscal agents for any services or supplies
1009 provided under the Medicaid program except for those services or
1010 supplies provided before the suspension or termination. No
1011 clinic, group, corporation or other association that is a provider
1012 of services shall submit claims for payment to the division or its
1013 fiscal agents for any services or supplies provided by a person
1014 within that organization who has been suspended or terminated from
1015 participation in the Medicaid program except for those services or
1016 supplies provided before the suspension or termination. When this
1017 provision is violated by a provider of services that is a clinic,
1018 group, corporation or other association, the division may suspend
1019 or terminate that organization from participation. Suspension may
1020 be applied by the division to all known affiliates of a provider,
1021 provided that each decision to include an affiliate is made on a
1022 case-by-case basis after giving due regard to all relevant facts
1023 and circumstances. The violation, failure or inadequacy of
1024 performance may be imputed to a person with whom the provider is
1025 affiliated where that conduct was accomplished within the course
1026 of his official duty or was effectuated by him with the knowledge
1027 or approval of that person.

1028 (7) The division may deny or revoke enrollment in the
1029 Medicaid program to a provider if any of the following are found
1030 to be applicable to the provider, his agent, a managing employee
1031 or any person having an ownership interest equal to five percent
1032 (5%) or greater in the provider:

1033 (a) Failure to truthfully or fully disclose any and all
1034 information required, or the concealment of any and all
1035 information required, on a claim, a provider application or a
1036 provider agreement, or the making of a false or misleading
1037 statement to the division relative to the Medicaid program.

1038 (b) Previous or current exclusion, suspension,
1039 termination from or the involuntary withdrawing from participation



1040 in the Medicaid program, any other state's Medicaid program,
1041 Medicare or any other public or private health or health insurance
1042 program. If the division ascertains that a provider has been
1043 convicted of a felony under federal or state law for an offense
1044 that the division determines is detrimental to the best interest
1045 of the program or of Medicaid beneficiaries, the division may
1046 refuse to enter into an agreement with that provider, or may
1047 terminate or refuse to renew an existing agreement.

1048 (c) Conviction under federal or state law of a criminal
1049 offense relating to the delivery of any goods, services or
1050 supplies, including the performance of management or
1051 administrative services relating to the delivery of the goods,
1052 services or supplies, under the Medicaid program, any other
1053 state's Medicaid program, Medicare or any other public or private
1054 health or health insurance program.

1055 (d) Conviction under federal or state law of a criminal
1056 offense relating to the neglect or abuse of a patient in
1057 connection with the delivery of any goods, services or supplies.

1058 (e) Conviction under federal or state law of a criminal
1059 offense relating to the unlawful manufacture, distribution,
1060 prescription or dispensing of a controlled substance.

1061 (f) Conviction under federal or state law of a criminal
1062 offense relating to fraud, theft, embezzlement, breach of
1063 fiduciary responsibility or other financial misconduct.

1064 (g) Conviction under federal or state law of a criminal
1065 offense punishable by imprisonment of a year or more that involves
1066 moral turpitude, or acts against the elderly, children or infirm.

1067 (h) Conviction under federal or state law of a criminal
1068 offense in connection with the interference or obstruction of any
1069 investigation into any criminal offense listed in paragraphs (c)
1070 through (i) of this subsection.

1071 (i) Sanction for a violation of federal or state laws
1072 or rules relative to the Medicaid program, any other state's



1073 Medicaid program, Medicare or any other public health care or
1074 health insurance program.

1075 (j) Revocation of license or certification.

1076 (k) Failure to pay recovery properly assessed or
1077 pursuant to an approved repayment schedule under the Medicaid
1078 program.

1079 (l) Failure to meet any condition of enrollment.

1080 **SECTION 3.** Section 43-13-123, Mississippi Code of 1972, is
1081 amended as follows:

1082 43-13-123. The determination of the method of providing
1083 payment of claims under this article shall be made by the
1084 division, with approval of the Governor, which methods may be:

1085 (a) By contract with insurance companies licensed to do
1086 business in the State of Mississippi or with nonprofit hospital
1087 service corporations, medical or dental service corporations,
1088 authorized to do business in Mississippi to underwrite on an
1089 insured premium approach, such medical assistance benefits as may
1090 be available, and any carrier selected under the provisions of
1091 this article is * * * expressly authorized and empowered to
1092 undertake the performance of the requirements of that contract.

1093 (b) By contract with an insurance company licensed to
1094 do business in the State of Mississippi or with nonprofit hospital
1095 service, medical or dental service organizations, or other
1096 organizations including data processing companies, authorized to
1097 do business in Mississippi to act as fiscal agent.

1098 The division shall obtain services to be provided under
1099 either of the above-described provisions in accordance with the
1100 Personal Service Contract Review Board Procurement
1101 Regulations. * * *

1102 The authorization of the foregoing methods shall not preclude
1103 other methods of providing payment of claims through direct
1104 operation of the program by the state or its agencies.



1105 **SECTION 4.** Section 43-13-127, Mississippi Code of 1972, is
1106 amended as follows:

1107 43-13-127. (1) Within sixty (60) days after the end of each
1108 fiscal year and at each regular session of the Legislature, the
1109 division shall make and publish a report to the Governor and to
1110 the Legislature, showing for the period of time covered the
1111 following:

1112 (a) The total number of recipients;

1113 (b) The total amount paid for medical assistance and
1114 care under this article;

1115 (c) The total number of applications;

1116 (d) The number of applications approved;

1117 (e) The number of applications denied;

1118 (f) The amount expended for administration of the
1119 provisions of this article;

1120 (g) The amount of money received from the federal
1121 government, if any;

1122 (h) The amount of money recovered by reason of
1123 collections from third persons by reason of assignment or
1124 subrogation, and the disposition of the same;

1125 (i) The actions and activities of the division in
1126 detecting and investigating suspected or alleged fraudulent
1127 practices, violations and abuses of the program; and

1128 (j) Any recommendations it may have as to expanding,
1129 enlarging, limiting or restricting the eligibility of persons
1130 covered by this article or services provided by this article, to
1131 make more effective the basic purposes of this article; to
1132 eliminate or curtail fraudulent practices and inequities in the
1133 plan or administration thereof; and to continue to participate in
1134 receiving federal funds for the furnishing of medical assistance
1135 under Title XIX of the Social Security Act or other federal law.

1136 (2) In addition to the reports required by subsection (1) of
1137 this section, the division shall submit a report each month to the



1138 Chairmen of the Public Health and Welfare Committees of the Senate
1139 and the House of Representatives and to the Joint Legislative
1140 Budget Committee that contains the information specified in each
1141 paragraph of subsection (1) for the preceding month.

1142 **SECTION 5.** Section 43-13-145, Mississippi Code of 1972, is
1143 amended as follows:

1144 **[Through June 30, 2002, subsection (1) of this section shall**
1145 **read as follows:]**

1146 43-13-145. (1) Upon each nursing facility * * * and each
1147 intermediate care facility for the mentally retarded licensed by
1148 the State of Mississippi, there is levied an assessment in the
1149 amount of Two Dollars (\$2.00) per day * * * for each * * *
1150 licensed and/or certified bed of the facility. The division may
1151 apply for a waiver from the United States Secretary of Health and
1152 Human Services to exempt nonprofit, public, charitable or
1153 religious facilities from the assessment levied under this
1154 subsection, and if a waiver is granted, those facilities shall be
1155 exempt from any assessment levied under this subsection after the
1156 date that the division receives notice that the waiver has been
1157 granted.

1158 **[From and after July 1, 2002, subsection (1) of this section**
1159 **shall read as follows:]**

1160 43-13-145. (1) (a) Upon each nursing facility and each
1161 intermediate care facility for the mentally retarded licensed by
1162 the State of Mississippi, there is levied an assessment in the
1163 amount of Three Dollars (\$3.00) per day for each licensed and/or
1164 certified bed of the facility. The division may apply for a
1165 waiver from the United States Secretary of Health and Human
1166 Services to exempt nonprofit, public, charitable or religious
1167 facilities from the assessment levied under this subsection, and
1168 if a waiver is granted, those facilities shall be exempt from any
1169 assessment levied under this subsection after the date that the
1170 division receives notice that the waiver has been granted.



1171 (b) A nursing facility or intermediate care facility
1172 for the mentally retarded is exempt from the assessment levied
1173 under this subsection if the facility is operated under the
1174 direction and control of:

1175 (i) The United States Veterans Administration or
1176 other agency or department of the United States government;

1177 (ii) The State Veterans Affairs Board;

1178 (iii) The University of Mississippi Medical
1179 Center; or

1180 (iv) A state agency or a state facility that
1181 either provides its own state match through intergovernmental
1182 transfer or certification of funds to the division.

1183 (2) (a) Upon each psychiatric residential treatment
1184 facility licensed by the State of Mississippi, there is levied an
1185 assessment in the amount of Three Dollars (\$3.00) per day for each
1186 licensed and/or certified bed of the facility.

1187 (b) A psychiatric residential treatment facility is
1188 exempt from the assessment levied under this subsection if the
1189 facility is operated under the direction and control of:

1190 (i) The United States Veterans Administration or
1191 other agency or department of the United States government;

1192 (ii) The University of Mississippi Medical Center;

1193 (iii) A state agency or a state facility that
1194 either provides its own state match through intergovernmental
1195 transfer or certification of funds to the division.

1196 (3) (a) Upon each hospital licensed by the State of
1197 Mississippi, there is levied an assessment in the amount of One
1198 Dollar and Fifty Cents (\$1.50) per day for each licensed inpatient
1199 acute care bed of the hospital.

1200 (b) A hospital is exempt from the assessment levied
1201 under this subsection if the hospital is operated under the
1202 direction and control of:



1203 (i) The United States Veterans Administration or
1204 other agency or department of the United States government;
1205 (ii) The University of Mississippi Medical Center;
1206 or
1207 (iii) A state agency or a state facility that
1208 either provides its own state match through intergovernmental
1209 transfer or certification of funds to the division.

1210 (4) Each health care facility that is subject to the
1211 provisions of this section shall keep and preserve such suitable
1212 books and records as may be necessary to determine the amount of
1213 assessment for which it is liable under this section. The books
1214 and records shall be kept and preserved for a period of not less
1215 than five (5) years, and those books and records shall be open for
1216 examination during business hours by the division, the State Tax
1217 Commission, the Office of the Attorney General and the State
1218 Department of Health.

1219 (5) The assessment levied under this section shall be
1220 collected by the division each month beginning on the effective
1221 date of Senate Bill No. 2189, 2002 Regular Session.

1222 (6) All assessments collected under this section shall be
1223 deposited in the Medical Care Fund created by Section 43-13-143.

1224 (7) The assessment levied under this section shall be in
1225 addition to any other assessments, taxes or fees levied by law,
1226 and the assessment shall constitute a debt due the State of
1227 Mississippi from the time the assessment is due until it is paid.

1228 (8) (a) If a health care facility that is liable for
1229 payment of the assessment levied under this section does not pay
1230 the assessment when it is due, the division shall give written
1231 notice to the health care facility by certified or registered mail
1232 demanding payment of the assessment within ten (10) days from the
1233 date of delivery of the notice. * * * If the health care facility
1234 fails or refuses to pay the assessment after receiving the notice
1235 and demand from the division, the division shall withhold from any



1236 Medicaid reimbursement payments that are due to the health care
1237 facility the amount of the unpaid assessment and a penalty of ten
1238 percent (10%) of the amount of the assessment, plus the legal rate
1239 of interest until the assessment is paid in full. If the health
1240 care facility does not participate in the Medicaid program, the
1241 division shall turn over to the Office of the Attorney General the
1242 collection of the unpaid assessment by civil action. In any such
1243 civil action, the Office of the Attorney General shall collect the
1244 amount of the unpaid assessment and a penalty of ten percent (10%)
1245 of the amount of the assessment, plus the legal rate of interest
1246 until the assessment is paid in full.

1247 (b) As an additional or alternative method for
1248 collecting unpaid assessments under this section, if a health care
1249 facility fails or refuses to pay the assessment after receiving
1250 notice and demand from the division, the division may file a
1251 notice of a tax lien with the circuit clerk of the county in which
1252 the health care facility is located, for the amount of the unpaid
1253 assessment and a penalty of ten percent (10%) of the amount of the
1254 assessment, plus the legal rate of interest until the assessment
1255 is paid in full. Immediately upon receipt of notice of the tax
1256 lien for the assessment, the circuit clerk shall enter the notice
1257 of the tax lien as a judgment upon the judgment roll and show in
1258 the appropriate columns the name of the health care facility as
1259 judgment debtor, the name of the division as judgment creditor,
1260 the amount of the unpaid assessment, and the date and time or
1261 enrollment. The judgment shall be valid as against mortgagees,
1262 pledgees, entrusters, purchasers, judgment creditors and other
1263 persons from the time of filing with the clerk. The amount of the
1264 judgment shall be a debt due the State of Mississippi and remain a
1265 lien upon the tangible property of the health care facility until
1266 the judgment is satisfied. The judgment shall be the equivalent
1267 of any enrolled judgment of a court of record and shall serve as



1268 authority for the issuance of writs of execution, writs of
1269 attachment or other remedial writs.

1270 **SECTION 6.** Section 41-7-191, Mississippi Code of 1972, is
1271 amended as follows:

1272 41-7-191. (1) No person shall engage in any of the
1273 following activities without obtaining the required certificate of
1274 need:

1275 (a) The construction, development or other
1276 establishment of a new health care facility;

1277 (b) The relocation of a health care facility or portion
1278 thereof, or major medical equipment, unless such relocation of a
1279 health care facility or portion thereof, or major medical
1280 equipment, which does not involve a capital expenditure by or on
1281 behalf of a health care facility, is within five thousand two
1282 hundred eighty (5,280) feet from the main entrance of the health
1283 care facility;

1284 (c) Any change * * * in the existing bed complement of
1285 any health care facility through the addition or conversion of any
1286 beds or the alteration, modernizing or refurbishing of any unit or
1287 department in which the beds may be located; * * *

1288 (d) Offering of the following health services if those
1289 services have not been provided on a regular basis by the proposed
1290 provider of such services within the period of twelve (12) months
1291 prior to the time such services would be offered:

1292 (i) Open heart surgery services;

1293 (ii) Cardiac catheterization services;

1294 (iii) Comprehensive inpatient rehabilitation
1295 services;

1296 (iv) Licensed psychiatric services;

1297 (v) Licensed chemical dependency services;

1298 (vi) Radiation therapy services;

1299 (vii) Diagnostic imaging services of an invasive
1300 nature, i.e. invasive digital angiography;



1301 (viii) Nursing home care as defined in
1302 subparagraphs (iv), (vi) and (viii) of Section 41-7-173(h);
1303 (ix) Home health services;
1304 (x) Swing-bed services;
1305 (xi) Ambulatory surgical services;
1306 (xii) Magnetic resonance imaging services;
1307 (xiii) Extracorporeal shock wave lithotripsy
1308 services;
1309 (xiv) Long-term care hospital services;
1310 (xv) Positron Emission Tomography (PET) services;
1311 (e) The relocation of one or more health services from
1312 one physical facility or site to another physical facility or
1313 site, unless such relocation, which does not involve a capital
1314 expenditure by or on behalf of a health care facility, (i) is to a
1315 physical facility or site within one thousand three hundred twenty
1316 (1,320) feet from the main entrance of the health care facility
1317 where the health care service is located, or (ii) is the result of
1318 an order of a court of appropriate jurisdiction or a result of
1319 pending litigation in such court, or by order of the State
1320 Department of Health, or by order of any other agency or legal
1321 entity of the state, the federal government, or any political
1322 subdivision of either, whose order is also approved by the State
1323 Department of Health;
1324 (f) The acquisition or otherwise control of any major
1325 medical equipment for the provision of medical services; provided,
1326 however, (i) the acquisition of any major medical equipment used
1327 only for research purposes, and (ii) the acquisition of major
1328 medical equipment to replace medical equipment for which a
1329 facility is already providing medical services and for which the
1330 State Department of Health has been notified before the date of
1331 such acquisition shall be exempt from this paragraph; an
1332 acquisition for less than fair market value must be reviewed, if
1333 the acquisition at fair market value would be subject to review;



1334 (g) Changes of ownership of existing health care
1335 facilities in which a notice of intent is not filed with the State
1336 Department of Health at least thirty (30) days prior to the date
1337 such change of ownership occurs, or a change in services or bed
1338 capacity as prescribed in paragraph (c) or (d) of this subsection
1339 as a result of the change of ownership; an acquisition for less
1340 than fair market value must be reviewed, if the acquisition at
1341 fair market value would be subject to review;

1342 (h) The change of ownership of any health care facility
1343 defined in subparagraphs (iv), (vi) and (viii) of Section
1344 41-7-173(h), in which a notice of intent as described in paragraph
1345 (g) has not been filed and if the Executive Director, Division of
1346 Medicaid, Office of the Governor, has not certified in writing
1347 that there will be no increase in allowable costs to Medicaid from
1348 revaluation of the assets or from increased interest and
1349 depreciation as a result of the proposed change of ownership;

1350 (i) Any activity described in paragraphs (a) through
1351 (h) if undertaken by any person if that same activity would
1352 require certificate of need approval if undertaken by a health
1353 care facility;

1354 (j) Any capital expenditure or deferred capital
1355 expenditure by or on behalf of a health care facility not covered
1356 by paragraphs (a) through (h);

1357 (k) The contracting of a health care facility as
1358 defined in subparagraphs (i) through (viii) of Section 41-7-173(h)
1359 to establish a home office, subunit, or branch office in the space
1360 operated as a health care facility through a formal arrangement
1361 with an existing health care facility as defined in subparagraph
1362 (ix) of Section 41-7-173(h).

1363 (2) The State Department of Health shall not grant approval
1364 for or issue a certificate of need to any person proposing the new
1365 construction of, addition to, or expansion of any health care
1366 facility defined in subparagraphs (iv) (skilled nursing facility)



1367 and (vi) (intermediate care facility) of Section 41-7-173(h) or
1368 the conversion of vacant hospital beds to provide skilled or
1369 intermediate nursing home care, except as hereinafter authorized:

1370 (a) The department may issue a certificate of need to
1371 any person proposing the new construction of any health care
1372 facility defined in subparagraphs (iv) and (vi) of Section
1373 41-7-173(h) as part of a life care retirement facility, in any
1374 county bordering on the Gulf of Mexico in which is located a
1375 National Aeronautics and Space Administration facility, not to
1376 exceed forty (40) beds. From and after July 1, 1999, there shall
1377 be no prohibition or restrictions on participation in the Medicaid
1378 program (Section 43-13-101 et seq.) for the beds in the health
1379 care facility that were authorized under this paragraph (a).

1380 (b) The department may issue certificates of need in
1381 Harrison County to provide skilled nursing home care for
1382 Alzheimer's disease patients and other patients, not to exceed one
1383 hundred fifty (150) beds. From and after July 1, 1999, there
1384 shall be no prohibition or restrictions on participation in the
1385 Medicaid program (Section 43-13-101 et seq.) for the beds in the
1386 nursing facilities that were authorized under this paragraph (b).

1387 (c) The department may issue a certificate of need for
1388 the addition to or expansion of any skilled nursing facility that
1389 is part of an existing continuing care retirement community
1390 located in Madison County, provided that the recipient of the
1391 certificate of need agrees in writing that the skilled nursing
1392 facility will not at any time participate in the Medicaid program
1393 (Section 43-13-101 et seq.) or admit or keep any patients in the
1394 skilled nursing facility who are participating in the Medicaid
1395 program. This written agreement by the recipient of the
1396 certificate of need shall be fully binding on any subsequent owner
1397 of the skilled nursing facility, if the ownership of the facility
1398 is transferred at any time after the issuance of the certificate
1399 of need. Agreement that the skilled nursing facility will not



1400 participate in the Medicaid program shall be a condition of the
1401 issuance of a certificate of need to any person under this
1402 paragraph (c), and if such skilled nursing facility at any time
1403 after the issuance of the certificate of need, regardless of the
1404 ownership of the facility, participates in the Medicaid program or
1405 admits or keeps any patients in the facility who are participating
1406 in the Medicaid program, the State Department of Health shall
1407 revoke the certificate of need, if it is still outstanding, and
1408 shall deny or revoke the license of the skilled nursing facility,
1409 at the time that the department determines, after a hearing
1410 complying with due process, that the facility has failed to comply
1411 with any of the conditions upon which the certificate of need was
1412 issued, as provided in this paragraph and in the written agreement
1413 by the recipient of the certificate of need. The total number of
1414 beds that may be authorized under the authority of this paragraph
1415 (c) shall not exceed sixty (60) beds.

1416 (d) The State Department of Health may issue a
1417 certificate of need to any hospital located in DeSoto County for
1418 the new construction of a skilled nursing facility, not to exceed
1419 one hundred twenty (120) beds, in DeSoto County. From and after
1420 July 1, 1999, there shall be no prohibition or restrictions on
1421 participation in the Medicaid program (Section 43-13-101 et seq.)
1422 for the beds in the nursing facility that were authorized under
1423 this paragraph (d).

1424 (e) The State Department of Health may issue a
1425 certificate of need for the construction of a nursing facility or
1426 the conversion of beds to nursing facility beds at a personal care
1427 facility for the elderly in Lowndes County that is owned and
1428 operated by a Mississippi nonprofit corporation, not to exceed
1429 sixty (60) beds. From and after July 1, 1999, there shall be no
1430 prohibition or restrictions on participation in the Medicaid
1431 program (Section 43-13-101 et seq.) for the beds in the nursing
1432 facility that were authorized under this paragraph (e).



1433 (f) The State Department of Health may issue a
1434 certificate of need for conversion of a county hospital facility
1435 in Itawamba County to a nursing facility, not to exceed sixty (60)
1436 beds, including any necessary construction, renovation or
1437 expansion. From and after July 1, 1999, there shall be no
1438 prohibition or restrictions on participation in the Medicaid
1439 program (Section 43-13-101 et seq.) for the beds in the nursing
1440 facility that were authorized under this paragraph (f).

1441 (g) The State Department of Health may issue a
1442 certificate of need for the construction or expansion of nursing
1443 facility beds or the conversion of other beds to nursing facility
1444 beds in either Hinds, Madison or Rankin County, not to exceed
1445 sixty (60) beds. From and after July 1, 1999, there shall be no
1446 prohibition or restrictions on participation in the Medicaid
1447 program (Section 43-13-101 et seq.) for the beds in the nursing
1448 facility that were authorized under this paragraph (g).

1449 (h) The State Department of Health may issue a
1450 certificate of need for the construction or expansion of nursing
1451 facility beds or the conversion of other beds to nursing facility
1452 beds in either Hancock, Harrison or Jackson County, not to exceed
1453 sixty (60) beds. From and after July 1, 1999, there shall be no
1454 prohibition or restrictions on participation in the Medicaid
1455 program (Section 43-13-101 et seq.) for the beds in the facility
1456 that were authorized under this paragraph (h).

1457 (i) The department may issue a certificate of need for
1458 the new construction of a skilled nursing facility in Leake
1459 County, provided that the recipient of the certificate of need
1460 agrees in writing that the skilled nursing facility will not at
1461 any time participate in the Medicaid program (Section 43-13-101 et
1462 seq.) or admit or keep any patients in the skilled nursing
1463 facility who are participating in the Medicaid program. This
1464 written agreement by the recipient of the certificate of need
1465 shall be fully binding on any subsequent owner of the skilled



1466 nursing facility, if the ownership of the facility is transferred
1467 at any time after the issuance of the certificate of need.
1468 Agreement that the skilled nursing facility will not participate
1469 in the Medicaid program shall be a condition of the issuance of a
1470 certificate of need to any person under this paragraph (i), and if
1471 such skilled nursing facility at any time after the issuance of
1472 the certificate of need, regardless of the ownership of the
1473 facility, participates in the Medicaid program or admits or keeps
1474 any patients in the facility who are participating in the Medicaid
1475 program, the State Department of Health shall revoke the
1476 certificate of need, if it is still outstanding, and shall deny or
1477 revoke the license of the skilled nursing facility, at the time
1478 that the department determines, after a hearing complying with due
1479 process, that the facility has failed to comply with any of the
1480 conditions upon which the certificate of need was issued, as
1481 provided in this paragraph and in the written agreement by the
1482 recipient of the certificate of need. The provision of Section
1483 43-7-193(1) regarding substantial compliance of the projection of
1484 need as reported in the current State Health Plan is waived for
1485 the purposes of this paragraph. The total number of nursing
1486 facility beds that may be authorized by any certificate of need
1487 issued under this paragraph (i) shall not exceed sixty (60) beds.
1488 If the skilled nursing facility authorized by the certificate of
1489 need issued under this paragraph is not constructed and fully
1490 operational within eighteen (18) months after July 1, 1994, the
1491 State Department of Health, after a hearing complying with due
1492 process, shall revoke the certificate of need, if it is still
1493 outstanding, and shall not issue a license for the skilled nursing
1494 facility at any time after the expiration of the eighteen-month
1495 period.

1496 (j) The department may issue certificates of need to
1497 allow any existing freestanding long-term care facility in
1498 Tishomingo County and Hancock County that on July 1, 1995, is



1499 licensed with fewer than sixty (60) beds. For the purposes of
1500 this paragraph (j), the provision of Section 41-7-193(1) requiring
1501 substantial compliance with the projection of need as reported in
1502 the current State Health Plan is waived. From and after July 1,
1503 1999, there shall be no prohibition or restrictions on
1504 participation in the Medicaid program (Section 43-13-101 et seq.)
1505 for the beds in the long-term care facilities that were authorized
1506 under this paragraph (j).

1507 (k) The department may issue a certificate of need for
1508 the construction of a nursing facility at a continuing care
1509 retirement community in Lowndes County. The total number of beds
1510 that may be authorized under the authority of this paragraph (k)
1511 shall not exceed sixty (60) beds. From and after July 1, 2001,
1512 the prohibition on the facility participating in the Medicaid
1513 program (Section 43-13-101 et seq.) that was a condition of
1514 issuance of the certificate of need under this paragraph (k) shall
1515 be revised as follows: The nursing facility may participate in
1516 the Medicaid program from and after July 1, 2001, if the owner of
1517 the facility on July 1, 2001, agrees in writing that no more than
1518 thirty (30) of the beds at the facility will be certified for
1519 participation in the Medicaid program, and that no claim will be
1520 submitted for Medicaid reimbursement for more than thirty (30)
1521 patients in the facility in any month or for any patient in the
1522 facility who is in a bed that is not Medicaid-certified. This
1523 written agreement by the owner of the facility shall be a
1524 condition of licensure of the facility, and the agreement shall be
1525 fully binding on any subsequent owner of the facility if the
1526 ownership of the facility is transferred at any time after July 1,
1527 2001. After this written agreement is executed, the Division of
1528 Medicaid and the State Department of Health shall not certify more
1529 than thirty (30) of the beds in the facility for participation in
1530 the Medicaid program. If the facility violates the terms of the
1531 written agreement by admitting or keeping in the facility on a



1532 regular or continuing basis more than thirty (30) patients who are
1533 participating in the Medicaid program, the State Department of
1534 Health shall revoke the license of the facility, at the time that
1535 the department determines, after a hearing complying with due
1536 process, that the facility has violated the written agreement.

1537 (1) Provided that funds are specifically appropriated
1538 therefor by the Legislature, the department may issue a
1539 certificate of need to a rehabilitation hospital in Hinds County
1540 for the construction of a sixty-bed long-term care nursing
1541 facility dedicated to the care and treatment of persons with
1542 severe disabilities including persons with spinal cord and
1543 closed-head injuries and ventilator-dependent patients. The
1544 provision of Section 41-7-193(1) regarding substantial compliance
1545 with projection of need as reported in the current State Health
1546 Plan is hereby waived for the purpose of this paragraph.

1547 (m) The State Department of Health may issue a
1548 certificate of need to a county-owned hospital in the Second
1549 Judicial District of Panola County for the conversion of not more
1550 than seventy-two (72) hospital beds to nursing facility beds,
1551 provided that the recipient of the certificate of need agrees in
1552 writing that none of the beds at the nursing facility will be
1553 certified for participation in the Medicaid program (Section
1554 43-13-101 et seq.), and that no claim will be submitted for
1555 Medicaid reimbursement in the nursing facility in any day or for
1556 any patient in the nursing facility. This written agreement by
1557 the recipient of the certificate of need shall be a condition of
1558 the issuance of the certificate of need under this paragraph, and
1559 the agreement shall be fully binding on any subsequent owner of
1560 the nursing facility if the ownership of the nursing facility is
1561 transferred at any time after the issuance of the certificate of
1562 need. After this written agreement is executed, the Division of
1563 Medicaid and the State Department of Health shall not certify any
1564 of the beds in the nursing facility for participation in the



1565 Medicaid program. If the nursing facility violates the terms of
1566 the written agreement by admitting or keeping in the nursing
1567 facility on a regular or continuing basis any patients who are
1568 participating in the Medicaid program, the State Department of
1569 Health shall revoke the license of the nursing facility, at the
1570 time that the department determines, after a hearing complying
1571 with due process, that the nursing facility has violated the
1572 condition upon which the certificate of need was issued, as
1573 provided in this paragraph and in the written agreement. If the
1574 certificate of need authorized under this paragraph is not issued
1575 within twelve (12) months after July 1, 2001, the department shall
1576 deny the application for the certificate of need and shall not
1577 issue the certificate of need at any time after the twelve-month
1578 period, unless the issuance is contested. If the certificate of
1579 need is issued and substantial construction of the nursing
1580 facility beds has not commenced within eighteen (18) months after
1581 July 1, 2001, the State Department of Health, after a hearing
1582 complying with due process, shall revoke the certificate of need
1583 if it is still outstanding, and the department shall not issue a
1584 license for the nursing facility at any time after the
1585 eighteen-month period. Provided, however, that if the issuance of
1586 the certificate of need is contested, the department shall require
1587 substantial construction of the nursing facility beds within six
1588 (6) months after final adjudication on the issuance of the
1589 certificate of need.

1590 (n) The department may issue a certificate of need for
1591 the new construction, addition or conversion of skilled nursing
1592 facility beds in Madison County, provided that the recipient of
1593 the certificate of need agrees in writing that the skilled nursing
1594 facility will not at any time participate in the Medicaid program
1595 (Section 43-13-101 et seq.) or admit or keep any patients in the
1596 skilled nursing facility who are participating in the Medicaid
1597 program. This written agreement by the recipient of the



1598 certificate of need shall be fully binding on any subsequent owner
1599 of the skilled nursing facility, if the ownership of the facility
1600 is transferred at any time after the issuance of the certificate
1601 of need. Agreement that the skilled nursing facility will not
1602 participate in the Medicaid program shall be a condition of the
1603 issuance of a certificate of need to any person under this
1604 paragraph (n), and if such skilled nursing facility at any time
1605 after the issuance of the certificate of need, regardless of the
1606 ownership of the facility, participates in the Medicaid program or
1607 admits or keeps any patients in the facility who are participating
1608 in the Medicaid program, the State Department of Health shall
1609 revoke the certificate of need, if it is still outstanding, and
1610 shall deny or revoke the license of the skilled nursing facility,
1611 at the time that the department determines, after a hearing
1612 complying with due process, that the facility has failed to comply
1613 with any of the conditions upon which the certificate of need was
1614 issued, as provided in this paragraph and in the written agreement
1615 by the recipient of the certificate of need. The total number of
1616 nursing facility beds that may be authorized by any certificate of
1617 need issued under this paragraph (n) shall not exceed sixty (60)
1618 beds. If the certificate of need authorized under this paragraph
1619 is not issued within twelve (12) months after July 1, 1998, the
1620 department shall deny the application for the certificate of need
1621 and shall not issue the certificate of need at any time after the
1622 twelve-month period, unless the issuance is contested. If the
1623 certificate of need is issued and substantial construction of the
1624 nursing facility beds has not commenced within eighteen (18)
1625 months after the effective date of July 1, 1998, the State
1626 Department of Health, after a hearing complying with due process,
1627 shall revoke the certificate of need if it is still outstanding,
1628 and the department shall not issue a license for the nursing
1629 facility at any time after the eighteen-month period. Provided,
1630 however, that if the issuance of the certificate of need is



1631 contested, the department shall require substantial construction
1632 of the nursing facility beds within six (6) months after final
1633 adjudication on the issuance of the certificate of need.

1634 (o) The department may issue a certificate of need for
1635 the new construction, addition or conversion of skilled nursing
1636 facility beds in Leake County, provided that the recipient of the
1637 certificate of need agrees in writing that the skilled nursing
1638 facility will not at any time participate in the Medicaid program
1639 (Section 43-13-101 et seq.) or admit or keep any patients in the
1640 skilled nursing facility who are participating in the Medicaid
1641 program. This written agreement by the recipient of the
1642 certificate of need shall be fully binding on any subsequent owner
1643 of the skilled nursing facility, if the ownership of the facility
1644 is transferred at any time after the issuance of the certificate
1645 of need. Agreement that the skilled nursing facility will not
1646 participate in the Medicaid program shall be a condition of the
1647 issuance of a certificate of need to any person under this
1648 paragraph (o), and if such skilled nursing facility at any time
1649 after the issuance of the certificate of need, regardless of the
1650 ownership of the facility, participates in the Medicaid program or
1651 admits or keeps any patients in the facility who are participating
1652 in the Medicaid program, the State Department of Health shall
1653 revoke the certificate of need, if it is still outstanding, and
1654 shall deny or revoke the license of the skilled nursing facility,
1655 at the time that the department determines, after a hearing
1656 complying with due process, that the facility has failed to comply
1657 with any of the conditions upon which the certificate of need was
1658 issued, as provided in this paragraph and in the written agreement
1659 by the recipient of the certificate of need. The total number of
1660 nursing facility beds that may be authorized by any certificate of
1661 need issued under this paragraph (o) shall not exceed sixty (60)
1662 beds. If the certificate of need authorized under this paragraph
1663 is not issued within twelve (12) months after July 1, 2001, the



1664 department shall deny the application for the certificate of need
1665 and shall not issue the certificate of need at any time after the
1666 twelve-month period, unless the issuance is contested. If the
1667 certificate of need is issued and substantial construction of the
1668 nursing facility beds has not commenced within eighteen (18)
1669 months after the effective date of July 1, 2001, the State
1670 Department of Health, after a hearing complying with due process,
1671 shall revoke the certificate of need if it is still outstanding,
1672 and the department shall not issue a license for the nursing
1673 facility at any time after the eighteen-month period. Provided,
1674 however, that if the issuance of the certificate of need is
1675 contested, the department shall require substantial construction
1676 of the nursing facility beds within six (6) months after final
1677 adjudication on the issuance of the certificate of need.

1678 (p) The department may issue a certificate of need for
1679 the construction of a municipally-owned nursing facility within
1680 the Town of Belmont in Tishomingo County, not to exceed sixty (60)
1681 beds, provided that the recipient of the certificate of need
1682 agrees in writing that the skilled nursing facility will not at
1683 any time participate in the Medicaid program (Section 43-13-101 et
1684 seq.) or admit or keep any patients in the skilled nursing
1685 facility who are participating in the Medicaid program. This
1686 written agreement by the recipient of the certificate of need
1687 shall be fully binding on any subsequent owner of the skilled
1688 nursing facility, if the ownership of the facility is transferred
1689 at any time after the issuance of the certificate of need.

1690 Agreement that the skilled nursing facility will not participate
1691 in the Medicaid program shall be a condition of the issuance of a
1692 certificate of need to any person under this paragraph (p), and if
1693 such skilled nursing facility at any time after the issuance of
1694 the certificate of need, regardless of the ownership of the
1695 facility, participates in the Medicaid program or admits or keeps
1696 any patients in the facility who are participating in the Medicaid



1697 program, the State Department of Health shall revoke the
1698 certificate of need, if it is still outstanding, and shall deny or
1699 revoke the license of the skilled nursing facility, at the time
1700 that the department determines, after a hearing complying with due
1701 process, that the facility has failed to comply with any of the
1702 conditions upon which the certificate of need was issued, as
1703 provided in this paragraph and in the written agreement by the
1704 recipient of the certificate of need. The provision of Section
1705 43-7-193(1) regarding substantial compliance of the projection of
1706 need as reported in the current State Health Plan is waived for
1707 the purposes of this paragraph. If the certificate of need
1708 authorized under this paragraph is not issued within twelve (12)
1709 months after July 1, 1998, the department shall deny the
1710 application for the certificate of need and shall not issue the
1711 certificate of need at any time after the twelve-month period,
1712 unless the issuance is contested. If the certificate of need is
1713 issued and substantial construction of the nursing facility beds
1714 has not commenced within eighteen (18) months after July 1, 1998,
1715 the State Department of Health, after a hearing complying with due
1716 process, shall revoke the certificate of need if it is still
1717 outstanding, and the department shall not issue a license for the
1718 nursing facility at any time after the eighteen-month period.
1719 Provided, however, that if the issuance of the certificate of need
1720 is contested, the department shall require substantial
1721 construction of the nursing facility beds within six (6) months
1722 after final adjudication on the issuance of the certificate of
1723 need.

1724 (q) (i) Beginning on July 1, 1999, the State
1725 Department of Health shall issue certificates of need during each
1726 of the next four (4) fiscal years for the construction or
1727 expansion of nursing facility beds or the conversion of other beds
1728 to nursing facility beds in each county in the state having a need
1729 for fifty (50) or more additional nursing facility beds, as shown



1730 in the fiscal year 1999 State Health Plan, in the manner provided
1731 in this paragraph (q). The total number of nursing facility beds
1732 that may be authorized by any certificate of need authorized under
1733 this paragraph (q) shall not exceed sixty (60) beds.

1734 (ii) Subject to the provisions of subparagraph
1735 (v), during each of the next four (4) fiscal years, the department
1736 shall issue six (6) certificates of need for new nursing facility
1737 beds, as follows: During fiscal years 2000, 2001 and 2002, one
1738 (1) certificate of need shall be issued for new nursing facility
1739 beds in the county in each of the four (4) Long-Term Care Planning
1740 Districts designated in the fiscal year 1999 State Health Plan
1741 that has the highest need in the district for those beds; and two
1742 (2) certificates of need shall be issued for new nursing facility
1743 beds in the two (2) counties from the state at large that have the
1744 highest need in the state for those beds, when considering the
1745 need on a statewide basis and without regard to the Long-Term Care
1746 Planning Districts in which the counties are located. During
1747 fiscal year 2003, one (1) certificate of need shall be issued for
1748 new nursing facility beds in any county having a need for fifty
1749 (50) or more additional nursing facility beds, as shown in the
1750 fiscal year 1999 State Health Plan, that has not received a
1751 certificate of need under this paragraph (q) during the three (3)
1752 previous fiscal years. During fiscal year 2000, in addition to
1753 the six (6) certificates of need authorized in this subparagraph,
1754 the department also shall issue a certificate of need for new
1755 nursing facility beds in Amite County and a certificate of need
1756 for new nursing facility beds in Carroll County.

1757 (iii) Subject to the provisions of subparagraph
1758 (v), the certificate of need issued under subparagraph (ii) for
1759 nursing facility beds in each Long-Term Care Planning District
1760 during each fiscal year shall first be available for nursing
1761 facility beds in the county in the district having the highest
1762 need for those beds, as shown in the fiscal year 1999 State Health



1763 Plan. If there are no applications for a certificate of need for
1764 nursing facility beds in the county having the highest need for
1765 those beds by the date specified by the department, then the
1766 certificate of need shall be available for nursing facility beds
1767 in other counties in the district in descending order of the need
1768 for those beds, from the county with the second highest need to
1769 the county with the lowest need, until an application is received
1770 for nursing facility beds in an eligible county in the district.

1771 (iv) Subject to the provisions of subparagraph
1772 (v), the certificate of need issued under subparagraph (ii) for
1773 nursing facility beds in the two (2) counties from the state at
1774 large during each fiscal year shall first be available for nursing
1775 facility beds in the two (2) counties that have the highest need
1776 in the state for those beds, as shown in the fiscal year 1999
1777 State Health Plan, when considering the need on a statewide basis
1778 and without regard to the Long-Term Care Planning Districts in
1779 which the counties are located. If there are no applications for
1780 a certificate of need for nursing facility beds in either of the
1781 two (2) counties having the highest need for those beds on a
1782 statewide basis by the date specified by the department, then the
1783 certificate of need shall be available for nursing facility beds
1784 in other counties from the state at large in descending order of
1785 the need for those beds on a statewide basis, from the county with
1786 the second highest need to the county with the lowest need, until
1787 an application is received for nursing facility beds in an
1788 eligible county from the state at large.

1789 (v) If a certificate of need is authorized to be
1790 issued under this paragraph (q) for nursing facility beds in a
1791 county on the basis of the need in the Long-Term Care Planning
1792 District during any fiscal year of the four-year period, a
1793 certificate of need shall not also be available under this
1794 paragraph (q) for additional nursing facility beds in that county
1795 on the basis of the need in the state at large, and that county



1796 shall be excluded in determining which counties have the highest
1797 need for nursing facility beds in the state at large for that
1798 fiscal year. After a certificate of need has been issued under
1799 this paragraph (q) for nursing facility beds in a county during
1800 any fiscal year of the four-year period, a certificate of need
1801 shall not be available again under this paragraph (q) for
1802 additional nursing facility beds in that county during the
1803 four-year period, and that county shall be excluded in determining
1804 which counties have the highest need for nursing facility beds in
1805 succeeding fiscal years.

1806 (vi) If more than one (1) application is made for
1807 a certificate of need for nursing home facility beds available
1808 under this paragraph (q), in Yalobusha, Newton or Tallahatchie
1809 County, and one (1) of the applicants is a county-owned hospital
1810 located in the county where the nursing facility beds are
1811 available, the department shall give priority to the county-owned
1812 hospital in granting the certificate of need if the following
1813 conditions are met:

1814 1. The county-owned hospital fully meets all
1815 applicable criteria and standards required to obtain a certificate
1816 of need for the nursing facility beds; and

1817 2. The county-owned hospital's qualifications
1818 for the certificate of need, as shown in its application and as
1819 determined by the department, are at least equal to the
1820 qualifications of the other applicants for the certificate of
1821 need.

1822 (r) (i) Beginning on July 1, 1999, the State
1823 Department of Health shall issue certificates of need during each
1824 of the next two (2) fiscal years for the construction or expansion
1825 of nursing facility beds or the conversion of other beds to
1826 nursing facility beds in each of the four (4) Long-Term Care
1827 Planning Districts designated in the fiscal year 1999 State Health



1828 Plan, to provide care exclusively to patients with Alzheimer's
1829 disease.

1830 (ii) Not more than twenty (20) beds may be
1831 authorized by any certificate of need issued under this paragraph
1832 (r), and not more than a total of sixty (60) beds may be
1833 authorized in any Long-Term Care Planning District by all
1834 certificates of need issued under this paragraph (r). However,
1835 the total number of beds that may be authorized by all
1836 certificates of need issued under this paragraph (r) during any
1837 fiscal year shall not exceed one hundred twenty (120) beds, and
1838 the total number of beds that may be authorized in any Long-Term
1839 Care Planning District during any fiscal year shall not exceed
1840 forty (40) beds. Of the certificates of need that are issued for
1841 each Long-Term Care Planning District during the next two (2)
1842 fiscal years, at least one (1) shall be issued for beds in the
1843 northern part of the district, at least one (1) shall be issued
1844 for beds in the central part of the district, and at least one (1)
1845 shall be issued for beds in the southern part of the district.

1846 (iii) The State Department of Health, in
1847 consultation with the Department of Mental Health and the Division
1848 of Medicaid, shall develop and prescribe the staffing levels,
1849 space requirements and other standards and requirements that must
1850 be met with regard to the nursing facility beds authorized under
1851 this paragraph (r) to provide care exclusively to patients with
1852 Alzheimer's disease.

1853 (3) The State Department of Health may grant approval for
1854 and issue certificates of need to any person proposing the new
1855 construction of, addition to, conversion of beds of or expansion
1856 of any health care facility defined in subparagraph (x)
1857 (psychiatric residential treatment facility) of Section
1858 41-7-173(h). The total number of beds which may be authorized by
1859 such certificates of need shall not exceed three hundred
1860 thirty-four (334) beds for the entire state.



1861 (a) Of the total number of beds authorized under this
1862 subsection, the department shall issue a certificate of need to a
1863 privately-owned psychiatric residential treatment facility in
1864 Simpson County for the conversion of sixteen (16) intermediate
1865 care facility for the mentally retarded (ICF-MR) beds to
1866 psychiatric residential treatment facility beds, provided that
1867 facility agrees in writing that the facility shall give priority
1868 for the use of those sixteen (16) beds to Mississippi residents
1869 who are presently being treated in out-of-state facilities.

1870 (b) Of the total number of beds authorized under this
1871 subsection, the department may issue a certificate or certificates
1872 of need for the construction or expansion of psychiatric
1873 residential treatment facility beds or the conversion of other
1874 beds to psychiatric residential treatment facility beds in Warren
1875 County, not to exceed sixty (60) psychiatric residential treatment
1876 facility beds, provided that the facility agrees in writing that
1877 no more than thirty (30) of the beds at the psychiatric
1878 residential treatment facility will be certified for participation
1879 in the Medicaid program (Section 43-13-101 et seq.) for the use of
1880 any patients other than those who are participating only in the
1881 Medicaid program of another state, and that no claim will be
1882 submitted to the Division of Medicaid for Medicaid reimbursement
1883 for more than thirty (30) patients in the psychiatric residential
1884 treatment facility in any day or for any patient in the
1885 psychiatric residential treatment facility who is in a bed that is
1886 not Medicaid-certified. This written agreement by the recipient
1887 of the certificate of need shall be a condition of the issuance of
1888 the certificate of need under this paragraph, and the agreement
1889 shall be fully binding on any subsequent owner of the psychiatric
1890 residential treatment facility if the ownership of the facility is
1891 transferred at any time after the issuance of the certificate of
1892 need. After this written agreement is executed, the Division of
1893 Medicaid and the State Department of Health shall not certify more



1894 than thirty (30) of the beds in the psychiatric residential
1895 treatment facility for participation in the Medicaid program for
1896 the use of any patients other than those who are participating
1897 only in the Medicaid program of another state. If the psychiatric
1898 residential treatment facility violates the terms of the written
1899 agreement by admitting or keeping in the facility on a regular or
1900 continuing basis more than thirty (30) patients who are
1901 participating in the Mississippi Medicaid program, the State
1902 Department of Health shall revoke the license of the facility, at
1903 the time that the department determines, after a hearing complying
1904 with due process, that the facility has violated the condition
1905 upon which the certificate of need was issued, as provided in this
1906 paragraph and in the written agreement.

1907 The State Department of Health, on or before July 1, 2002,
1908 shall transfer the certificate of need authorized under the
1909 authority of this paragraph (b), or reissue the certificate of
1910 need if it has expired, to River Region Health System.

1911 (c) Of the total number of beds authorized under this
1912 subsection, the department shall issue a certificate of need to a
1913 hospital currently operating Medicaid-certified acute psychiatric
1914 beds for adolescents in DeSoto County, for the establishment of a
1915 forty-bed psychiatric residential treatment facility in DeSoto
1916 County, provided that the hospital agrees in writing (i) that the
1917 hospital shall give priority for the use of those forty (40) beds
1918 to Mississippi residents who are presently being treated in
1919 out-of-state facilities, and (ii) that no more than fifteen (15)
1920 of the beds at the psychiatric residential treatment facility will
1921 be certified for participation in the Medicaid program (Section
1922 43-13-101 et seq.), and that no claim will be submitted for
1923 Medicaid reimbursement for more than fifteen (15) patients in the
1924 psychiatric residential treatment facility in any day or for any
1925 patient in the psychiatric residential treatment facility who is
1926 in a bed that is not Medicaid-certified. This written agreement



1927 by the recipient of the certificate of need shall be a condition
1928 of the issuance of the certificate of need under this paragraph,
1929 and the agreement shall be fully binding on any subsequent owner
1930 of the psychiatric residential treatment facility if the ownership
1931 of the facility is transferred at any time after the issuance of
1932 the certificate of need. After this written agreement is
1933 executed, the Division of Medicaid and the State Department of
1934 Health shall not certify more than fifteen (15) of the beds in the
1935 psychiatric residential treatment facility for participation in
1936 the Medicaid program. If the psychiatric residential treatment
1937 facility violates the terms of the written agreement by admitting
1938 or keeping in the facility on a regular or continuing basis more
1939 than fifteen (15) patients who are participating in the Medicaid
1940 program, the State Department of Health shall revoke the license
1941 of the facility, at the time that the department determines, after
1942 a hearing complying with due process, that the facility has
1943 violated the condition upon which the certificate of need was
1944 issued, as provided in this paragraph and in the written
1945 agreement.

1946 (d) Of the total number of beds authorized under this
1947 subsection, the department may issue a certificate or certificates
1948 of need for the construction or expansion of psychiatric
1949 residential treatment facility beds or the conversion of other
1950 beds to psychiatric treatment facility beds, not to exceed thirty
1951 (30) psychiatric residential treatment facility beds, in either
1952 Alcorn, Tishomingo, Prentiss, Lee, Itawamba, Monroe, Chickasaw,
1953 Pontotoc, Calhoun, Lafayette, Union, Benton or Tippah County.

1954 (e) Of the total number of beds authorized under this
1955 subsection (3) the department shall issue a certificate of need to
1956 a privately-owned, nonprofit psychiatric residential treatment
1957 facility in Hinds County for an eight-bed expansion of the
1958 facility, provided that the facility agrees in writing that the
1959 facility shall give priority for the use of those eight (8) beds



1960 to Mississippi residents who are presently being treated in
1961 out-of-state facilities.

1962 (f) The department shall issue a certificate of need to
1963 a one-hundred-thirty-four-bed specialty hospital located on
1964 twenty-nine and forty-four one-hundredths (29.44) commercial acres
1965 at 5900 Highway 39 North in Meridian (Lauderdale County),
1966 Mississippi, for the addition, construction or expansion of
1967 child/adolescent psychiatric residential treatment facility beds
1968 in Lauderdale County. As a condition of issuance of the
1969 certificate of need under this paragraph, the facility shall give
1970 priority in admissions to the child/adolescent psychiatric
1971 residential treatment facility beds authorized under this
1972 paragraph to patients who otherwise would require out-of-state
1973 placement. The Division of Medicaid, in conjunction with the
1974 Department of Human Services, shall furnish the facility a list of
1975 all out-of-state patients on a quarterly basis. Furthermore,
1976 notice shall also be provided to the parent, custodial parent or
1977 guardian of each out-of-state patient notifying them of the
1978 priority status granted by this paragraph. For purposes of this
1979 paragraph, the provisions of Section 41-7-193(1) requiring
1980 substantial compliance with the projection of need as reported in
1981 the current State Health Plan are waived. The total number of
1982 child/adolescent psychiatric residential treatment facility beds
1983 that may be authorized under the authority of this paragraph shall
1984 be sixty (60) beds. There shall be no prohibition or restrictions
1985 on participation in the Medicaid program (Section 43-13-101 et
1986 seq.) for the person receiving the certificate of need authorized
1987 under this paragraph or for the beds converted pursuant to the
1988 authority of that certificate of need.

1989 (4) (a) From and after July 1, 1993, the department shall
1990 not issue a certificate of need to any person for the new
1991 construction of any hospital, psychiatric hospital or chemical
1992 dependency hospital that will contain any child/adolescent



1993 psychiatric or child/adolescent chemical dependency beds, or for
1994 the conversion of any other health care facility to a hospital,
1995 psychiatric hospital or chemical dependency hospital that will
1996 contain any child/adolescent psychiatric or child/adolescent
1997 chemical dependency beds, or for the addition of any
1998 child/adolescent psychiatric or child/adolescent chemical
1999 dependency beds in any hospital, psychiatric hospital or chemical
2000 dependency hospital, or for the conversion of any beds of another
2001 category in any hospital, psychiatric hospital or chemical
2002 dependency hospital to child/adolescent psychiatric or
2003 child/adolescent chemical dependency beds, except as hereinafter
2004 authorized:

2005 (i) The department may issue certificates of need
2006 to any person for any purpose described in this subsection,
2007 provided that the hospital, psychiatric hospital or chemical
2008 dependency hospital does not participate in the Medicaid program
2009 (Section 43-13-101 et seq.) at the time of the application for the
2010 certificate of need and the owner of the hospital, psychiatric
2011 hospital or chemical dependency hospital agrees in writing that
2012 the hospital, psychiatric hospital or chemical dependency hospital
2013 will not at any time participate in the Medicaid program or admit
2014 or keep any patients who are participating in the Medicaid program
2015 in the hospital, psychiatric hospital or chemical dependency
2016 hospital. This written agreement by the recipient of the
2017 certificate of need shall be fully binding on any subsequent owner
2018 of the hospital, psychiatric hospital or chemical dependency
2019 hospital, if the ownership of the facility is transferred at any
2020 time after the issuance of the certificate of need. Agreement
2021 that the hospital, psychiatric hospital or chemical dependency
2022 hospital will not participate in the Medicaid program shall be a
2023 condition of the issuance of a certificate of need to any person
2024 under this subparagraph (a)(i), and if such hospital, psychiatric
2025 hospital or chemical dependency hospital at any time after the



2026 issuance of the certificate of need, regardless of the ownership
2027 of the facility, participates in the Medicaid program or admits or
2028 keeps any patients in the hospital, psychiatric hospital or
2029 chemical dependency hospital who are participating in the Medicaid
2030 program, the State Department of Health shall revoke the
2031 certificate of need, if it is still outstanding, and shall deny or
2032 revoke the license of the hospital, psychiatric hospital or
2033 chemical dependency hospital, at the time that the department
2034 determines, after a hearing complying with due process, that the
2035 hospital, psychiatric hospital or chemical dependency hospital has
2036 failed to comply with any of the conditions upon which the
2037 certificate of need was issued, as provided in this subparagraph
2038 and in the written agreement by the recipient of the certificate
2039 of need.

2040 (ii) The department may issue a certificate of
2041 need for the conversion of existing beds in a county hospital in
2042 Choctaw County from acute care beds to child/adolescent chemical
2043 dependency beds. For purposes of this subparagraph, the
2044 provisions of Section 41-7-193(1) requiring substantial compliance
2045 with the projection of need as reported in the current State
2046 Health Plan is waived. The total number of beds that may be
2047 authorized under authority of this subparagraph shall not exceed
2048 twenty (20) beds. There shall be no prohibition or restrictions
2049 on participation in the Medicaid program (Section 43-13-101 et
2050 seq.) for the hospital receiving the certificate of need
2051 authorized under this subparagraph (a)(ii) or for the beds
2052 converted pursuant to the authority of that certificate of need.

2053 (iii) The department may issue a certificate or
2054 certificates of need for the construction or expansion of
2055 child/adolescent psychiatric beds or the conversion of other beds
2056 to child/adolescent psychiatric beds in Warren County. For
2057 purposes of this subparagraph, the provisions of Section
2058 41-7-193(1) requiring substantial compliance with the projection



2059 of need as reported in the current State Health Plan are waived.
2060 The total number of beds that may be authorized under the
2061 authority of this subparagraph shall not exceed twenty (20) beds.
2062 There shall be no prohibition or restrictions on participation in
2063 the Medicaid program (Section 43-13-101 et seq.) for the person
2064 receiving the certificate of need authorized under this
2065 subparagraph (a)(iii) or for the beds converted pursuant to the
2066 authority of that certificate of need.

2067 If by January 1, 2002, there has been no significant
2068 commencement of construction of the beds authorized under this
2069 subparagraph (a)(iii), or no significant action taken to convert
2070 existing beds to the beds authorized under this subparagraph, then
2071 the certificate of need that was previously issued under this
2072 subparagraph shall expire. If the previously issued certificate
2073 of need expires, the department may accept applications for
2074 issuance of another certificate of need for the beds authorized
2075 under this subparagraph, and may issue a certificate of need to
2076 authorize the construction, expansion or conversion of the beds
2077 authorized under this subparagraph.

2078 (iv) The department shall issue a certificate of
2079 need to the Region 7 Mental Health/Retardation Commission for the
2080 construction or expansion of child/adolescent psychiatric beds or
2081 the conversion of other beds to child/adolescent psychiatric beds
2082 in any of the counties served by the commission. For purposes of
2083 this subparagraph, the provisions of Section 41-7-193(1) requiring
2084 substantial compliance with the projection of need as reported in
2085 the current State Health Plan is waived. The total number of beds
2086 that may be authorized under the authority of this subparagraph
2087 shall not exceed twenty (20) beds. There shall be no prohibition
2088 or restrictions on participation in the Medicaid program (Section
2089 43-13-101 et seq.) for the person receiving the certificate of
2090 need authorized under this subparagraph (a)(iv) or for the beds
2091 converted pursuant to the authority of that certificate of need.



2092 (v) The department may issue a certificate of need
2093 to any county hospital located in Leflore County for the
2094 construction or expansion of adult psychiatric beds or the
2095 conversion of other beds to adult psychiatric beds, not to exceed
2096 twenty (20) beds, provided that the recipient of the certificate
2097 of need agrees in writing that the adult psychiatric beds will not
2098 at any time be certified for participation in the Medicaid program
2099 and that the hospital will not admit or keep any patients who are
2100 participating in the Medicaid program in any of such adult
2101 psychiatric beds. This written agreement by the recipient of the
2102 certificate of need shall be fully binding on any subsequent owner
2103 of the hospital if the ownership of the hospital is transferred at
2104 any time after the issuance of the certificate of need. Agreement
2105 that the adult psychiatric beds will not be certified for
2106 participation in the Medicaid program shall be a condition of the
2107 issuance of a certificate of need to any person under this
2108 subparagraph (a)(v), and if such hospital at any time after the
2109 issuance of the certificate of need, regardless of the ownership
2110 of the hospital, has any of such adult psychiatric beds certified
2111 for participation in the Medicaid program or admits or keeps any
2112 Medicaid patients in such adult psychiatric beds, the State
2113 Department of Health shall revoke the certificate of need, if it
2114 is still outstanding, and shall deny or revoke the license of the
2115 hospital at the time that the department determines, after a
2116 hearing complying with due process, that the hospital has failed
2117 to comply with any of the conditions upon which the certificate of
2118 need was issued, as provided in this subparagraph and in the
2119 written agreement by the recipient of the certificate of need.

2120 (vi) The department may issue a certificate or
2121 certificates of need for the expansion of child psychiatric beds
2122 or the conversion of other beds to child psychiatric beds at the
2123 University of Mississippi Medical Center. For purposes of this
2124 subparagraph (a)(vi), the provision of Section 41-7-193(1)



2125 requiring substantial compliance with the projection of need as
2126 reported in the current State Health Plan is waived. The total
2127 number of beds that may be authorized under the authority of this
2128 subparagraph (a)(vi) shall not exceed fifteen (15) beds. There
2129 shall be no prohibition or restrictions on participation in the
2130 Medicaid program (Section 43-13-101 et seq.) for the hospital
2131 receiving the certificate of need authorized under this
2132 subparagraph (a)(vi) or for the beds converted pursuant to the
2133 authority of that certificate of need.

2134 (b) From and after July 1, 1990, no hospital,
2135 psychiatric hospital or chemical dependency hospital shall be
2136 authorized to add any child/adolescent psychiatric or
2137 child/adolescent chemical dependency beds or convert any beds of
2138 another category to child/adolescent psychiatric or
2139 child/adolescent chemical dependency beds without a certificate of
2140 need under the authority of subsection (1)(c) of this section.

2141 (5) The department may issue a certificate of need to a
2142 county hospital in Winston County for the conversion of fifteen
2143 (15) acute care beds to geriatric psychiatric care beds.

2144 (6) The State Department of Health shall issue a certificate
2145 of need to a Mississippi corporation qualified to manage a
2146 long-term care hospital as defined in Section 41-7-173(h)(xii) in
2147 Harrison County, not to exceed eighty (80) beds, including any
2148 necessary renovation or construction required for licensure and
2149 certification, provided that the recipient of the certificate of
2150 need agrees in writing that the long-term care hospital will not
2151 at any time participate in the Medicaid program (Section 43-13-101
2152 et seq.) or admit or keep any patients in the long-term care
2153 hospital who are participating in the Medicaid program. This
2154 written agreement by the recipient of the certificate of need
2155 shall be fully binding on any subsequent owner of the long-term
2156 care hospital, if the ownership of the facility is transferred at
2157 any time after the issuance of the certificate of need. Agreement



2158 that the long-term care hospital will not participate in the
2159 Medicaid program shall be a condition of the issuance of a
2160 certificate of need to any person under this subsection (6), and
2161 if such long-term care hospital at any time after the issuance of
2162 the certificate of need, regardless of the ownership of the
2163 facility, participates in the Medicaid program or admits or keeps
2164 any patients in the facility who are participating in the Medicaid
2165 program, the State Department of Health shall revoke the
2166 certificate of need, if it is still outstanding, and shall deny or
2167 revoke the license of the long-term care hospital, at the time
2168 that the department determines, after a hearing complying with due
2169 process, that the facility has failed to comply with any of the
2170 conditions upon which the certificate of need was issued, as
2171 provided in this subsection and in the written agreement by the
2172 recipient of the certificate of need. For purposes of this
2173 subsection, the provision of Section 41-7-193(1) requiring
2174 substantial compliance with the projection of need as reported in
2175 the current State Health Plan is hereby waived.

2176 (7) The State Department of Health may issue a certificate
2177 of need to any hospital in the state to utilize a portion of its
2178 beds for the "swing-bed" concept. Any such hospital must be in
2179 conformance with the federal regulations regarding such swing-bed
2180 concept at the time it submits its application for a certificate
2181 of need to the State Department of Health, except that such
2182 hospital may have more licensed beds or a higher average daily
2183 census (ADC) than the maximum number specified in federal
2184 regulations for participation in the swing-bed program. Any
2185 hospital meeting all federal requirements for participation in the
2186 swing-bed program which receives such certificate of need shall
2187 render services provided under the swing-bed concept to any
2188 patient eligible for Medicare (Title XVIII of the Social Security
2189 Act) who is certified by a physician to be in need of such
2190 services, and no such hospital shall permit any patient who is



2191 eligible for both Medicaid and Medicare or eligible only for
2192 Medicaid to stay in the swing beds of the hospital for more than
2193 thirty (30) days per admission unless the hospital receives prior
2194 approval for such patient from the Division of Medicaid, Office of
2195 the Governor. Any hospital having more licensed beds or a higher
2196 average daily census (ADC) than the maximum number specified in
2197 federal regulations for participation in the swing-bed program
2198 which receives such certificate of need shall develop a procedure
2199 to insure that before a patient is allowed to stay in the swing
2200 beds of the hospital, there are no vacant nursing home beds
2201 available for that patient located within a fifty-mile radius of
2202 the hospital. When any such hospital has a patient staying in the
2203 swing beds of the hospital and the hospital receives notice from a
2204 nursing home located within such radius that there is a vacant bed
2205 available for that patient, the hospital shall transfer the
2206 patient to the nursing home within a reasonable time after receipt
2207 of the notice. Any hospital which is subject to the requirements
2208 of the two (2) preceding sentences of this subsection may be
2209 suspended from participation in the swing-bed program for a
2210 reasonable period of time by the State Department of Health if the
2211 department, after a hearing complying with due process, determines
2212 that the hospital has failed to comply with any of those
2213 requirements.

2214 (8) The Department of Health shall not grant approval for or
2215 issue a certificate of need to any person proposing the new
2216 construction of, addition to or expansion of a health care
2217 facility as defined in subparagraph (viii) of Section 41-7-173(h).

2218 (9) The Department of Health shall not grant approval for or
2219 issue a certificate of need to any person proposing the
2220 establishment of, or expansion of the currently approved territory
2221 of, or the contracting to establish a home office, subunit or
2222 branch office within the space operated as a health care facility
2223 as defined in Section 41-7-173(h) (i) through (viii) by a health



2224 care facility as defined in subparagraph (ix) of Section
2225 41-7-173(h).

2226 (10) Health care facilities owned and/or operated by the
2227 state or its agencies are exempt from the restraints in this
2228 section against issuance of a certificate of need if such addition
2229 or expansion consists of repairing or renovation necessary to
2230 comply with the state licensure law. This exception shall not
2231 apply to the new construction of any building by such state
2232 facility. This exception shall not apply to any health care
2233 facilities owned and/or operated by counties, municipalities,
2234 districts, unincorporated areas, other defined persons, or any
2235 combination thereof.

2236 (11) The new construction, renovation or expansion of or
2237 addition to any health care facility defined in subparagraph (ii)
2238 (psychiatric hospital), subparagraph (iv) (skilled nursing
2239 facility), subparagraph (vi) (intermediate care facility),
2240 subparagraph (viii) (intermediate care facility for the mentally
2241 retarded) and subparagraph (x) (psychiatric residential treatment
2242 facility) of Section 41-7-173(h) which is owned by the State of
2243 Mississippi and under the direction and control of the State
2244 Department of Mental Health, and the addition of new beds or the
2245 conversion of beds from one category to another in any such
2246 defined health care facility which is owned by the State of
2247 Mississippi and under the direction and control of the State
2248 Department of Mental Health, shall not require the issuance of a
2249 certificate of need under Section 41-7-171 et seq.,
2250 notwithstanding any provision in Section 41-7-171 et seq. to the
2251 contrary.

2252 (12) The new construction, renovation or expansion of or
2253 addition to any veterans homes or domiciliaries for eligible
2254 veterans of the State of Mississippi as authorized under Section
2255 35-1-19 shall not require the issuance of a certificate of need,



2256 notwithstanding any provision in Section 41-7-171 et seq. to the
2257 contrary.

2258 (13) The new construction of a nursing facility or nursing
2259 facility beds or the conversion of other beds to nursing facility
2260 beds shall not require the issuance of a certificate of need,
2261 notwithstanding any provision in Section 41-7-171 et seq. to the
2262 contrary, if the conditions of this subsection are met.

2263 (a) Before any construction or conversion may be
2264 undertaken without a certificate of need, the owner of the nursing
2265 facility, in the case of an existing facility, or the applicant to
2266 construct a nursing facility, in the case of new construction,
2267 first must file a written notice of intent and sign a written
2268 agreement with the State Department of Health that the entire
2269 nursing facility will not at any time participate in or have any
2270 beds certified for participation in the Medicaid program (Section
2271 43-13-101 et seq.), will not admit or keep any patients in the
2272 nursing facility who are participating in the Medicaid program,
2273 and will not submit any claim for Medicaid reimbursement for any
2274 patient in the facility. This written agreement by the owner or
2275 applicant shall be a condition of exercising the authority under
2276 this subsection without a certificate of need, and the agreement
2277 shall be fully binding on any subsequent owner of the nursing
2278 facility if the ownership of the facility is transferred at any
2279 time after the agreement is signed. After the written agreement
2280 is signed, the Division of Medicaid and the State Department of
2281 Health shall not certify any beds in the nursing facility for
2282 participation in the Medicaid program. If the nursing facility
2283 violates the terms of the written agreement by participating in
2284 the Medicaid program, having any beds certified for participation
2285 in the Medicaid program, admitting or keeping any patient in the
2286 facility who is participating in the Medicaid program, or
2287 submitting any claim for Medicaid reimbursement for any patient in
2288 the facility, the State Department of Health shall revoke the



2289 license of the nursing facility at the time that the department
2290 determines, after a hearing complying with due process, that the
2291 facility has violated the terms of the written agreement.

2292 (b) For the purposes of this subsection, participation
2293 in the Medicaid program by a nursing facility includes Medicaid
2294 reimbursement of coinsurance and deductibles for recipients who
2295 are qualified Medicare beneficiaries and/or those who are dually
2296 eligible. Any nursing facility exercising the authority under
2297 this subsection may not bill or submit a claim to the Division of
2298 Medicaid for services to qualified Medicare beneficiaries and/or
2299 those who are dually eligible.

2300 (c) The new construction of a nursing facility or
2301 nursing facility beds or the conversion of other beds to nursing
2302 facility beds described in this section must be either a part of a
2303 completely new continuing care retirement community, as described
2304 in the latest edition of the Mississippi State Health Plan, or an
2305 addition to existing personal care and independent living
2306 components, and so that the completed project will be a continuing
2307 care retirement community, containing (i) independent living
2308 accommodations, (ii) personal care beds, and (iii) the nursing
2309 home facility beds. The three (3) components must be located on a
2310 single site and be operated as one (1) inseparable facility. The
2311 nursing facility component must contain a minimum of thirty (30)
2312 beds. Any nursing facility beds authorized by this section will
2313 not be counted against the bed need set forth in the State Health
2314 Plan, as identified in Section 41-7-171, et seq.

2315 This subsection (13) shall stand repealed from and after July
2316 1, 2005.

2317 (14) The State Department of Health shall issue a
2318 certificate of need to any hospital which is currently licensed
2319 for two hundred fifty (250) or more acute care beds and is located
2320 in any general hospital service area not having a comprehensive
2321 cancer center, for the establishment and equipping of such a



2322 center which provides facilities and services for outpatient
2323 radiation oncology therapy, outpatient medical oncology therapy,
2324 and appropriate support services including the provision of
2325 radiation therapy services. The provision of Section 41-7-193(1)
2326 regarding substantial compliance with the projection of need as
2327 reported in the current State Health Plan is waived for the
2328 purpose of this subsection.

2329 (15) The State Department of Health may authorize the
2330 transfer of hospital beds, not to exceed sixty (60) beds, from the
2331 North Panola Community Hospital to the South Panola Community
2332 Hospital. The authorization for the transfer of those beds shall
2333 be exempt from the certificate of need review process.

2334 (16) Nothing in this section or in any other provision of
2335 Section 41-7-171 et seq. shall prevent any nursing facility from
2336 designating an appropriate number of existing beds in the facility
2337 as beds for providing care exclusively to patients with
2338 Alzheimer's disease.

2339 **SECTION 7.** Any transfer of funds to the Department of Mental
2340 Health by a political subdivision or instrumentality of the state
2341 before the effective date of Senate Bill No. 2189, 2002 Regular
2342 Session, which funds were used to match federal funds to provide
2343 services under paragraph (29) of Section 43-13-117, is ratified,
2344 approved and confirmed.

2345 **SECTION 8.** This act shall take effect and be in force from
2346 and after its passage.

