By: Senator(s) Bryan

To: Public Health and Welfare; Appropriations

SENATE BILL NO. 2739

1 AN ACT ENTITLED THE "MISSISSIPPIANS' ACCESS TO HEALTHCARE ACT
2 OF 2002"; TO AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972, TO
3 DIRECT THE DIVISION OF MEDICAID TO APPLY FOR A FEDERAL 1115 WAIVER
4 FOR A PHARMACEUTICAL DRUG PROGRAM FOR NEEDY SENIORS; TO DIRECT THE
5 DIVISION OF MEDICAID TO APPLY FOR A FEDERAL 1115 WAIVER FOR A
6 DIABETES CASE MANAGEMENT PROGRAM FOR THE UNINSURED AND
7 UNDER-INSURED; TO DIRECT THE DIVISION OF MEDICAID TO APPLY FOR A
8 FEDERAL 1115 WAIVER FOR A CARDIOVASCULAR DISEASE CASE MANAGEMENT
9 PROGRAM FOR THE UNINSURED AND UNDER-INSURED; TO DIRECT THE
10 DIVISION OF MEDICAID TO APPLY FOR A FEDERAL 1115 WAIVER FOR A
11 BREAST AND CERVICAL CANCER PREVENTION PROGRAM FOR WOMEN AGE 40-50
12 AND OTHER HIGH-RISK INDIVIDUALS; TO AMEND SECTION 43-13-117,
13 MISSISSIPPI CODE OF 1972, TO DIRECT THE DIVISION OF MEDICAID TO
14 APPLY FOR A FEDERAL 1115 WAIVER TO PROVIDE SCHOOL NURSE SERVICES
15 TO ALL SCHOOL-AGE CHILDREN; TO AUTHORIZE THE DIVISION OF MEDICAID
16 TO ESTABLISH MEDICARE RATE REIMBURSEMENT FOR INPATIENT AND
17 OUTPATIENT SERVICES AT CRITICAL ACCESS HOSPITALS; TO AMEND SECTION
18 25-15-9, MISSISSIPPI CODE OF 1972, TO REMOVE THE DEDUCTIBLE FOR
19 NETWORK PHYSICIAN OFFICE VISITS BY THE EMPLOYEE OR A DEPENDENT,
20 APPLY A CO-PAY FOR A PHYSICIAN VISIT, AND APPLY A 20% CO-INSURANCE
21 REQUIREMENT FOR OTHER SERVICES PROVIDED IN THE PHYSICIAN'S OFFICE
22 NOT SUBJECT TO THE DEDUCTIBLE UNDER THE STATE AND SCHOOL EMPLOYEES
23 HEALTH INSURANCE PLAN; TO ESTABLISH THE MISSISSIPPI ACCESS TO CARE
24 (MAC) OVERSIGHT COMMITTEE TO COORDINATE THE IMPLEMENTATION,
25 FUNDING AND ANY NEEDED REVISIONS OF THE MAC PLAN FOR THE PROVISION
26 OF SERVICES TO PERSONS WITH DISABILITIES IN THE STATE OF
27 MISSISSIPPI; TO DIRECT THE DEPARTMENT OF MENTAL HEALTH, THE STATE
28 DEPARTMENT OF REHABILITATION SERVICES, THE DEPARTMENT OF HUMAN
29 SERVICES, THE STATE DEPARTMENT OF EDUCATION, THE DIVISION OF
30 MEDICAID AND THE MISSISSIPPI DEVELOPMENTAL DISABILITIES COUNCIL TO
31 PERFORM CERTAIN FUNCTIONS IN IMPLEMENTING THE MAC PLAN; TO AMEND
32 SECTION 41-79-5, MISSISSIPPI CODE OF 1972, TO CONFORM FUNDING
33 REFERENCES IN THE SCHOOL NURSE INTERVENTION PROGRAM; TO AMEND
34 SECTION 41-7-191, MISSISSIPPI CODE OF 1972, TO AUTHORIZE A HEALTH
35 CARE CERTIFICATE OF NEED TO A CERTAIN HOSPITAL TO PROVIDE
36 COMPREHENSIVE MEDICAL REHABILITATION SERVICES IN CERTAIN COUNTIES;
37 TO AMEND SECTIONS 43-13-407 AND 43-13-405, MISSISSIPPI CODE OF
38 1972, TO DIRECT THE STATE TREASURER TO TRANSFER $100 MILLION OF
39 THE 2002 TOBACCO SETTLEMENT INSTALLMENT PAYMENT, AND ANNUALLY
40 THEREAFTER, INTO THE HEALTH CARE EXPENDABLE FUND TO BE
41 APPROPRIATED TO THE DIVISION OF MEDICAID FOR FEDERAL WAIVER
42 PROGRAMS PURSUANT TO THE MISSISSIPPIANS' ACCESS TO HEALTHCARE
43 (MATH) ACT; AND FOR RELATED PURPOSES.

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

45 **SECTION 1.** This act shall be known and may be cited as the
46 "Mississippians' Access To Healthcare (MATH) Act of 2002."

47 **SECTION 2.** Section 43-13-115, Mississippi Code of 1972, is
48 amended as follows:
49 43-13-115. Recipients of medical assistance shall be the
50 following persons only:
51 (1) Who are qualified for public assistance grants
52 under provisions of Title IV-A and E of the federal Social
53 Security Act, as amended, as determined by the State Department of
54 Human Services, including those statutorily deemed to be IV-A and
55 low-income families and children under Section 1931 of the Social
56 Security Act as determined by the State Department of Human
57 Services and certified to the Division of Medicaid, but not
58 optional groups except as specifically covered in this section.
59 For the purposes of this paragraph (1) and paragraphs (8), (17)
60 and (18) of this section, any reference to Title IV-A or to Part A
61 of Title IV of the federal Social Security Act, as amended, or the
62 state plan under Title IV-A or Part A of Title IV, shall be
63 considered as a reference to Title IV-A of the federal Social
64 Security Act, as amended, and the state plan under Title IV-A,
65 including the income and resource standards and methodologies
66 under Title IV-A and the state plan, as they existed on July 16,
67 1996.
68 (2) Those qualified for Supplemental Security Income
69 (SSI) benefits under Title XVI of the federal Social Security Act,
70 as amended. The eligibility of individuals covered in this
71 paragraph shall be determined by the Social Security
72 Administration and certified to the Division of Medicaid.
73 (3) [Deleted]
74 (4) [Deleted]
75 (5) A child born on or after October 1, 1984, to a
76 woman eligible for and receiving medical assistance under the
77 state plan on the date of the child's birth shall be deemed to
78 have applied for medical assistance and to have been found
79 eligible for such assistance under such plan on the date of such

80 birth and will remain eligible for such assistance for a period of
81 one (1) year so long as the child is a member of the woman's
82 household and the woman remains eligible for such assistance or
83 would be eligible for assistance if pregnant. The eligibility of
84 individuals covered in this paragraph shall be determined by the
85 State Department of Human Services and certified to the Division
86 of Medicaid.

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

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

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

110 (8) Children under eighteen (18) years of age and
111 pregnant women (including those in intact families) who meet the
112 AFDC financial standards of the state plan approved under Title

113 IV-A of the federal Social Security Act, as amended. The
114 eligibility of children covered under this paragraph shall be
115 determined by the State Department of Human Services and certified
116 to the Division of Medicaid.
117 (9) Individuals who are:
118 (a) Children born after September 30, 1983, who
119 have not attained the age of nineteen (19), with family income
120 that does not exceed one hundred percent (100%) of the nonfarm
121 official poverty line;
122 (b) Pregnant women, infants and children who have
123 not attained the age of six (6), with family income that does not
124 exceed one hundred thirty-three percent (133%) of the federal
125 poverty level; and
126 (c) Pregnant women and infants who have not
127 attained the age of one (1), with family income that does not
128 exceed one hundred eighty-five percent (185%) of the federal
129 poverty level.
130 The eligibility of individuals covered in (a), (b) and (c) of
131 this paragraph shall be determined by the Department of Human
132 Services.
133 (10) Certain disabled children age eighteen (18) or
134 under who are living at home, who would be eligible, if in a
135 medical institution, for SSI or a state supplemental payment under
136 Title XVI of the federal Social Security Act, as amended, and
137 therefore for Medicaid under the plan, and for whom the state has
138 made a determination as required under Section 1902(e)(3)(b) of
139 the federal Social Security Act, as amended. The eligibility of
140 individuals under this paragraph shall be determined by the
141 Division of Medicaid.
142 (11) Individuals who are sixty-five (65) years of age
143 or older or are disabled as determined under Section 1614(a)(3) of
144 the federal Social Security Act, as amended, and whose income does
145 not exceed one hundred thirty-five percent (135%) of the nonfarm

146 official poverty line as defined by the Office of Management and
147 Budget and revised annually, and whose resources do not exceed
148 those established by the Division of Medicaid.
149 The eligibility of individuals covered under this paragraph
150 shall be determined by the Division of Medicaid, and such
151 individuals determined eligible shall receive the same Medicaid
152 services as other categorical eligible individuals.
153 (12) Individuals who are qualified Medicare
154 beneficiaries (QMB) entitled to Part A Medicare as defined under
155 Section 301, Public Law 100-360, known as the Medicare
156 Catastrophic Coverage Act of 1988, and whose income does not
157 exceed one hundred percent (100%) of the nonfarm official poverty
158 line as defined by the Office of Management and Budget and revised
159 annually.
160 The eligibility of individuals covered under this paragraph
161 shall be determined by the Division of Medicaid, and such
162 individuals determined eligible shall receive Medicare
163 cost-sharing expenses only as more fully defined by the Medicare
164 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
165 1997.
166 (13) (a) Individuals who are entitled to Medicare Part
167 A as defined in Section 4501 of the Omnibus Budget Reconciliation
168 Act of 1990, and whose income does not exceed one hundred twenty
169 percent (120%) of the nonfarm official poverty line as defined by
170 the Office of Management and Budget and revised annually.
171 Eligibility for Medicaid benefits is limited to full payment of
172 Medicare Part B premiums.
173 (b) Individuals entitled to Part A of Medicare,
174 with income above one hundred twenty percent (120%), but less than
175 one hundred thirty-five percent (135%) of the federal poverty
176 level, and not otherwise eligible for Medicaid. Eligibility for
177 Medicaid benefits is limited to full payment of Medicare Part B
178 premiums. The number of eligible individuals is limited by the

179 availability of the federal capped allocation at one hundred
180 percent (100%) of federal matching funds, as more fully defined in
181 the Balanced Budget Act of 1997.
182 (c) Individuals entitled to Part A of Medicare,
183 with income of at least one hundred thirty-five percent (135%),
184 but not exceeding one hundred seventy-five percent (175%) of the
185 federal poverty level, and not otherwise eligible for Medicaid.
186 Eligibility for Medicaid benefits is limited to partial payment of
187 Medicare Part B premiums. The number of eligible individuals is
188 limited by the availability of the federal capped allocation of
189 one hundred percent (100%) federal matching funds, as more fully
190 defined in the Balanced Budget Act of 1997.
191 The eligibility of individuals covered under this paragraph
192 shall be determined by the Division of Medicaid.
193 (14) [Deleted]
194 (15) Disabled workers who are eligible to enroll in
195 Part A Medicare as required by Public Law 101-239, known as the
196 Omnibus Budget Reconciliation Act of 1989, and whose income does
197 not exceed two hundred percent (200%) of the federal poverty level
198 as determined in accordance with the Supplemental Security Income
199 (SSI) program. The eligibility of individuals covered under this
200 paragraph shall be determined by the Division of Medicaid and such
201 individuals shall be entitled to buy-in coverage of Medicare Part
202 A premiums only under the provisions of this paragraph (15).
203 (16) In accordance with the terms and conditions of
204 approved Title XIX waiver from the United States Department of
205 Health and Human Services, persons provided home- and
206 community-based services who are physically disabled and certified
207 by the Division of Medicaid as eligible due to applying the income
208 and deeming requirements as if they were institutionalized.
209 (17) In accordance with the terms of the federal
210 Personal Responsibility and Work Opportunity Reconciliation Act of
211 1996 (Public Law 104-193), persons who become ineligible for

212 assistance under Title IV-A of the federal Social Security Act, as
213 amended, because of increased income from or hours of employment
214 of the caretaker relative or because of the expiration of the
215 applicable earned income disregards, who were eligible for
216 Medicaid for at least three (3) of the six (6) months preceding
217 the month in which such ineligibility begins, shall be eligible
218 for Medicaid assistance for up to twenty-four (24) months;
219 however, Medicaid assistance for more than twelve (12) months may
220 be provided only if a federal waiver is obtained to provide such
221 assistance for more than twelve (12) months and federal and state
222 funds are available to provide such assistance.

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

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

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

242 (21) Women of childbearing age whose family income does
243 not exceed one hundred eighty-five percent (185%) of the federal
244 poverty level. The eligibility of individuals covered under this

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

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

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

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

277 covered under this paragraph (22) shall be determined by the
278 Division of Medicaid.
279 The Division of Medicaid shall apply to the United States
280 Secretary of Health and Human Services for a federal waiver of the
281 applicable provisions of Title XIX of the federal Social Security
282 Act, as amended, and any other applicable provisions of federal
283 law as necessary to allow for the implementation of this paragraph
284 (22). The provisions of this paragraph (22) shall be implemented
285 from and after the date that the Division of Medicaid receives the
286 federal waiver.
287 (23) Children certified by the Mississippi Department
288 of Human Services for whom the state and county human services
289 agency has custody and financial responsibility who are in foster
290 care on their eighteenth birthday as reported by the Mississippi
291 Department of Human Services shall be certified Medicaid eligible
292 by the Division of Medicaid until their twenty-first birthday.
293 (24) Individuals who have not attained age sixty-five
294 (65), are not otherwise covered by creditable coverage as defined
295 in the Public Health Services Act, and have been screened for
296 breast and cervical cancer under the Centers for Disease Control
297 and Prevention Breast and Cervical Cancer Early Detection Program
298 established under Title XV of the Public Health Service Act in
299 accordance with the requirements of that act and who need
300 treatment for breast or cervical cancer. Eligibility of
301 individuals under this paragraph (24) shall be determined by the
302 Division of Medicaid.
303 (25) Individuals who would be eligible for services in
304 a nursing home but who live in a noninstitutional setting, whose
305 income does not exceed the amount prescribed by federal regulation
306 for nursing home care, and who regularly expend more than fifty
307 percent (50%) of their monthly income on prescription drugs and
308 over-the-counter drugs.

309 The eligibility of individuals covered under this paragraph
310 (25) shall be determined by the Division of Medicaid. The
311 individuals determined eligible shall be eligible only for
312 prescription drugs and over-the-counter drugs covered under
313 Section 43-13-117(9) and not for any other services covered under
314 Section 43-13-117.

315 The Division of Medicaid shall apply to the United States
316 Secretary of Health and Human Services for a federal waiver of the
317 applicable provisions of Title XIX of the federal Social Security
318 Act, as amended, and any other applicable provisions of federal
319 law as necessary to allow for the implementation of this paragraph
320 (25). The provisions of this paragraph (25) shall be implemented
321 from and after the date that the Division of Medicaid receives the
322 federal waiver.

323 (26) With respect to the Medicaid Rx Senior
324 Eligibility Waiver Program in this paragraph (26):

325 (a) "Qualified Medicare Beneficiaries" means
326 Medicare beneficiaries with incomes equal to or below one hundred
327 percent (100%) of the federal poverty level who are eligible for
328 Medicaid assistance for the Part A and Part B Medicare premiums
329 and for Medicare deductibles and co-insurance requirements as set
330 forth in Section 1905(p)(1) of Title XIX of the Social Security
331 Act.

332 (b) "Specified Low-income Medicare
333 Beneficiaries" means Medicare beneficiaries who have incomes
334 greater than one hundred percent (100%) of the federal poverty
335 level and less than two hundred percent (200%) of the federal
336 poverty level and meet the requirements set forth in Section
337 1902(a)(E)(iii) of Title XIX of the Social Security Act.

338 Individuals eligible for the Medicaid Rx Senior Eligibility
339 Waiver Program shall be entitled to the Medicaid prescription drug
340 coverage as provided to Medicaid recipients as set forth in Title
341 XIX of the Social Security Act. To be eligible for the program,

342 an individual shall meet the following requirements: (a) be a
343 United States citizen or a lawfully admitted alien; (b) be a
344 resident of the State of Mississippi; (c) be at least sixty-five
345 (65) years of age; (d) meet the definition of a Qualified Medicare
346 Beneficiary or a Specified Low-income Medicare Beneficiary as set
347 forth in this paragraph (26); and (e) be ineligible for and/or not
348 receiving a prescription drug benefit through a Medicare
349 supplemental policy or any other third party payer prescription
350 benefit. The eligibility of individuals covered under this
351 paragraph (26) shall be determined by the Division of Medicaid.
352 Prescription drug coverage provided to eligible beneficiaries
353 under this paragraph (26) shall be phased-in statewide as funds
354 become available for this purpose.

355 The Division of Medicaid shall apply to the United States
356 Secretary of Health and Human Services for a federal 1115 waiver
357 of the applicable provisions of Title XIX of the federal Social
358 Security Act, as amended, and any other applicable provisions of
359 federal law as necessary to allow for the implementation of this
360 paragraph (26). The provisions of this paragraph (26) shall be
361 implemented from and after the date that the Division of Medicaid
362 receives the federal waiver.

363 (27) Persons who are workers with a potentially
364 severe disability, as determined by the division, shall be
365 eligible to receive diabetes case management services and Medicaid
366 benefits. The term "worker with a potentially severe disability"
367 means a person who is at least sixteen (16) years of age but under
368 sixty-five (65) years of age, who has a physical or mental
369 impairment that is reasonably expected to cause the person to
370 become blind or disabled as defined under Section 1614(a) of the
371 federal Social Security Act, as amended, if the person does not
372 receive diabetes case management services and other services
373 provided under Medicaid, the intention being to serve all
374 uninsured or under-insured working population in Mississippi

375 identified on the 2000 federal decennial census. Eligible
376 individuals will receive regular Medicaid benefits on a
377 fee-for-service basis. In addition to regular Medicaid services,
378 the eligible individual will receive targeted diabetes case
379 management services, including (a) assessment of the eligible
380 individual to determine service needs; (b) development of a
381 specific care plan; (c) referral and related activities to help
382 the individual obtain needed services; and (d) monitoring and
383 follow-up. The eligibility of individuals covered under this
384 paragraph (27) shall be determined by the Division of Medicaid.
385 Services provided under this paragraph (27) shall be phased-in
386 statewide as funds become available for this purpose.
387 The Division of Medicaid shall apply to the United States
388 Secretary of Health and Human Services for a federal 1115 waiver
389 of the applicable provisions of Title XIX of the federal Social
390 Security Act, as amended, and any other applicable provisions of
391 federal law as necessary to allow for the implementation of this
392 paragraph (27). The provisions of this paragraph (27) shall be
393 implemented from and after the date that the Division of Medicaid
394 receives the federal waiver.
395 (28) Persons who are workers with a potentially
396 severe disability, as determined by the division, shall be
397 eligible to receive cardiovascular disease case management and
398 Medicaid benefits. The term "worker with a potentially severe
399 disability" means a person who is at least sixteen (16) years of
400 age but under sixty-five (65) years of age, who has a physical or
401 mental impairment that is reasonably expected to cause the person
402 to become blind or disabled as defined under Section 1614(a) of
403 the federal Social Security Act, as amended, if the person does
404 not receive cardiovascular disease case management services and
405 other services provided under Medicaid, the intention being to
406 serve all uninsured or under-insured working population in
407 Mississippi as identified in the 2000 federal decennial census.

408 The eligibility of individuals covered under this paragraph (28)
409 shall be determined by the Division of Medicaid. Eligible
410 individuals will receive regular Medicaid benefits on a fee-for
411 -service basis. In addition to the regular Medicaid services, the
412 eligible individual will receive targeted cardiovascular disease
413 case management services, including (a) assessment of the eligible
414 individual to determine service needs; (b) development of a
415 specific care plan; (c) referral and related activities to help
416 the individual obtain needed services; and (d) monitoring and
417 follow-up. Services provided under this paragraph (28) shall be
418 phased-in statewide as funds become available for this purpose.
419 The Division of Medicaid shall apply to the United States
420 Secretary of Health and Human Services for a federal 1115 waiver
421 of the applicable provisions of Title XIX of the federal Social
422 Security Act, as amended, and any other applicable provisions of
423 federal law as necessary to allow for the implementation of this
424 paragraph (28). The provisions of this paragraph (28) shall be
425 implemented from and after the date that the Division of Medicaid
426 receives the federal waiver.
427 (29) Individuals who are (a) forty (40) years of
428 age or over but have not attained age fifty (50), or (b) under
429 forty (40) years of age and are at high risk of breast cancer, or
430 (c) have evidence of breast mass, and are not otherwise covered by
431 creditable coverage as defined in the Public Health Services Act,
432 and have not been screened for breast and cervical cancer under
433 the Centers for Disease Control and Prevention Breast and Cervical
434 Cancer Early Detection Program established under the Public Health
435 Service Act, and who need screening for breast or cervical cancer.
436 The eligibility of individuals covered under this paragraph (29)
437 shall be determined by the Division of Medicaid. Services under
438 this paragraph (29) will include a visit to a physician for a Pap
439 test, a clinical breast examination, laboratory interpretation and
440 a mammography screening. Services provided under this paragraph

441 (29) shall be phased-in statewide as funds become available for
442 this purpose.
443 The Division of Medicaid shall apply to the United States
444 Secretary of Health and Human Services for a federal 1115 waiver
445 of the applicable provisions of Title XIX of the federal Social
446 Security Act, as amended, and any other applicable provisions of
447 federal law as necessary to allow for the implementation of this
448 paragraph (29). The provisions of this paragraph (29) shall be
449 implemented from and after the date that the Division of Medicaid
450 receives the federal waiver.
451 **SECTION 3.** Section 43-13-117, Mississippi Code of 1972, is
452 amended as follows:
453 43-13-117. Medical assistance as authorized by this article
454 shall include payment of part or all of the costs, at the
455 discretion of the division or its successor, with approval of the
456 Governor, of the following types of care and services rendered to
457 eligible applicants who shall have been determined to be eligible
458 for such care and services, within the limits of state
459 appropriations and federal matching funds:
460 (1) Inpatient hospital services.
461 (a) The division shall allow thirty (30) days of
462 inpatient hospital care annually for all Medicaid recipients.
463 Precertification of inpatient days must be obtained as required by
464 the division. The division shall be authorized to allow unlimited
465 days in disproportionate hospitals as defined by the division for
466 eligible infants under the age of six (6) years.
467 (b) From and after July 1, 1994, the Executive
468 Director of the Division of Medicaid shall amend the Mississippi
469 Title XIX Inpatient Hospital Reimbursement Plan to remove the
470 occupancy rate penalty from the calculation of the Medicaid
471 Capital Cost Component utilized to determine total hospital costs
472 allocated to the Medicaid program.

473 (c) Hospitals will receive an additional payment
474 for the implantable programmable baclofen drug pump used to treat
475 spasticity which is implanted on an inpatient basis. The payment
476 pursuant to written invoice will be in addition to the facility's
477 per diem reimbursement and will represent a reduction of costs on
478 the facility's annual cost report, and shall not exceed Ten
479 Thousand Dollars ($10,000.00) per year per recipient. This
480 paragraph (c) shall stand repealed on July 1, 2005.
481 (2) Outpatient hospital services. Provided that where
482 the same services are reimbursed as clinic services, the division
483 may revise the rate or methodology of outpatient reimbursement to
484 maintain consistency, efficiency, economy and quality of care.
485 The division shall develop a Medicaid-specific cost-to-charge
486 ratio calculation from data provided by hospitals to determine an
487 allowable rate payment for outpatient hospital services, and shall
488 submit a report thereon to the Medical Advisory Committee on or
489 before December 1, 1999. The committee shall make a
490 recommendation on the specific cost-to-charge reimbursement method
491 for outpatient hospital services to the 2000 Regular Session of
492 the Legislature.
493 (3) Laboratory and x-ray services.
494 (4) Nursing facility services.
495 (a) The division shall make full payment to
496 nursing facilities for each day, not exceeding fifty-two (52) days
497 per year, that a patient is absent from the facility on home
498 leave. Payment may be made for the following home leave days in
499 addition to the fifty-two-day limitation: Christmas, the day
500 before Christmas, the day after Christmas, Thanksgiving, the day
501 before Thanksgiving and the day after Thanksgiving.
502 (b) From and after July 1, 1997, the division
503 shall implement the integrated case-mix payment and quality
504 monitoring system, which includes the fair rental system for
505 property costs and in which recapture of depreciation is

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

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

517 (d) When a facility of a category that does not
518 require a certificate of need for construction and that could not
519 be eligible for Medicaid reimbursement is constructed to nursing
520 facility specifications for licensure and certification, and the
521 facility is subsequently converted to a nursing facility pursuant
522 to a certificate of need that authorizes conversion only and the
523 applicant for the certificate of need was assessed an application
524 review fee based on capital expenditures incurred in constructing
525 the facility, the division shall allow reimbursement for capital
526 expenditures necessary for construction of the facility that were
527 incurred within the twenty-four (24) consecutive calendar months
528 immediately preceding the date that the certificate of need
529 authorizing such conversion was issued, to the same extent that
530 reimbursement would be allowed for construction of a new nursing
531 facility pursuant to a certificate of need that authorizes such
532 construction. The reimbursement authorized in this subparagraph
533 (d) may be made only to facilities the construction of which was
534 completed after June 30, 1989. Before the division shall be
535 authorized to make the reimbursement authorized in this
536 subparagraph (d), the division first must have received approval
537 from the Health Care Financing Administration of the United States

538 Department of Health and Human Services of the change in the state
539 Medicaid plan providing for such reimbursement.
540 (e) The division shall develop and implement, not
541 later than January 1, 2001, a case-mix payment add-on determined
542 by time studies and other valid statistical data which will
543 reimburse a nursing facility for the additional cost of caring for
544 a resident who has a diagnosis of Alzheimer's or other related
545 dementia and exhibits symptoms that require special care. Any
546 such case-mix add-on payment shall be supported by a determination
547 of additional cost. The division shall also develop and implement
548 as part of the fair rental reimbursement system for nursing
549 facility beds, an Alzheimer's resident bed depreciation enhanced
550 reimbursement system which will provide an incentive to encourage
551 nursing facilities to convert or construct beds for residents with
552 Alzheimer's or other related dementia.
553 (f) The Division of Medicaid shall develop and
554 implement a referral process for long-term care alternatives for
555 Medicaid beneficiaries and applicants. No Medicaid beneficiary
556 shall be admitted to a Medicaid-certified nursing facility unless
557 a licensed physician certifies that nursing facility care is
558 appropriate for that person on a standardized form to be prepared
559 and provided to nursing facilities by the Division of Medicaid.
560 The physician shall forward a copy of that certification to the
561 Division of Medicaid within twenty-four (24) hours after it is
562 signed by the physician. Any physician who fails to forward the
563 certification to the Division of Medicaid within the time period
564 specified in this paragraph shall be ineligible for Medicaid
565 reimbursement for any physician's services performed for the
566 applicant. The Division of Medicaid shall determine, through an
567 assessment of the applicant conducted within two (2) business days
568 after receipt of the physician's certification, whether the
569 applicant also could live appropriately and cost-effectively at
570 home or in some other community-based setting if home- or

571 community-based services were available to the applicant. The
572 time limitation prescribed in this paragraph shall be waived in
573 cases of emergency. If the Division of Medicaid determines that a
574 home- or other community-based setting is appropriate and
575 cost-effective, the division shall:
576 (i) Advise the applicant or the applicant's
577 legal representative that a home- or other community-based setting
578 is appropriate;
579 (ii) Provide a proposed care plan and inform
580 the applicant or the applicant's legal representative regarding
581 the degree to which the services in the care plan are available in
582 a home- or in other community-based setting rather than nursing
583 facility care; and
584 (iii) Explain that such plan and services are
585 available only if the applicant or the applicant's legal
586 representative chooses a home- or community-based alternative to
587 nursing facility care, and that the applicant is free to choose
588 nursing facility care.
589 The Division of Medicaid may provide the services described
590 in this paragraph (f) directly or through contract with case
591 managers from the local Area Agencies on Aging, and shall
592 coordinate long-term care alternatives to avoid duplication with
593 hospital discharge planning procedures.
594 Placement in a nursing facility may not be denied by the
595 division if home- or community-based services that would be more
596 appropriate than nursing facility care are not actually available,
597 or if the applicant chooses not to receive the appropriate home-
598 or community-based services.
599 The division shall provide an opportunity for a fair hearing
600 under federal regulations to any applicant who is not given the
601 choice of home- or community-based services as an alternative to
602 institutional care.

603 The division shall make full payment for long-term care
604 alternative services.
605 The division shall apply for necessary federal waivers to
606 assure that additional services providing alternatives to nursing
607 facility care are made available to applicants for nursing
608 facility care.
609 (5) Periodic screening and diagnostic services for
610 individuals under age twenty-one (21) years as are needed to
611 identify physical and mental defects and to provide health care
612 treatment and other measures designed to correct or ameliorate
613 defects and physical and mental illness and conditions discovered
614 by the screening services regardless of whether these services are
615 included in the state plan. The division may include in its
616 periodic screening and diagnostic program those discretionary
617 services authorized under the federal regulations adopted to
618 implement Title XIX of the federal Social Security Act, as
619 amended. The division, in obtaining physical therapy services,
620 occupational therapy services, and services for individuals with
621 speech, hearing and language disorders, may enter into a
622 cooperative agreement with the State Department of Education for
623 the provision of such services to handicapped students by public
624 school districts using state funds which are provided from the
625 appropriation to the Department of Education to obtain federal
626 matching funds through the division. The division, in obtaining
627 medical and psychological evaluations for children in the custody
628 of the State Department of Human Services may enter into a
629 cooperative agreement with the State Department of Human Services
630 for the provision of such services using state funds which are
631 provided from the appropriation to the Department of Human
632 Services to obtain federal matching funds through the division.
633 On July 1, 1993, all fees for periodic screening and
634 diagnostic services under this paragraph (5) shall be increased by

635 twenty-five percent (25%) of the reimbursement rate in effect on
636 June 30, 1993.
637 (6) Physician's services. The division shall allow
638 twelve (12) physician visits annually. All fees for physicians'
639 services that are covered only by Medicaid shall be reimbursed at
640 ninety percent (90%) of the rate established on January 1, 1999,
641 and as adjusted each January thereafter, under Medicare (Title
642 XVIII of the Social Security Act, as amended), and which shall in
643 no event be less than seventy percent (70%) of the rate
644 established on January 1, 1994. All fees for physicians' services
645 that are covered by both Medicare and Medicaid shall be reimbursed
646 at ten percent (10%) of the adjusted Medicare payment established
647 on January 1, 1999, and as adjusted each January thereafter, under
648 Medicare (Title XVIII of the Social Security Act, as amended), and
649 which shall in no event be less than seventy percent (70%) of the
650 adjusted Medicare payment established on January 1, 1994.
651 (7) (a) Home health services for eligible persons, not
652 to exceed in cost the prevailing cost of nursing facility
653 services, not to exceed sixty (60) visits per year. All home
654 health visits must be precertified as required by the division.
655 (b) Repealed.
656 (8) Emergency medical transportation services. On
657 January 1, 1994, emergency medical transportation services shall
658 be reimbursed at seventy percent (70%) of the rate established
659 under Medicare (Title XVIII of the Social Security Act, as
660 amended). "Emergency medical transportation services" shall mean,
661 but shall not be limited to, the following services by a properly
662 permitted ambulance operated by a properly licensed provider in
663 accordance with the Emergency Medical Services Act of 1974
664 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
665 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
666 (vi) disposable supplies, (vii) similar services.

667 (9) Legend and other drugs as may be determined by the
668 division. The division may implement a program of prior approval
669 for drugs to the extent permitted by law. Payment by the division
670 for covered multiple source drugs shall be limited to the lower of
671 the upper limits established and published by the Health Care
672 Financing Administration (HCFA) plus a dispensing fee of Four
673 Dollars and Ninety-one Cents ($4.91), or the estimated acquisition
674 cost (EAC) as determined by the division plus a dispensing fee of
675 Four Dollars and Ninety-one Cents ($4.91), or the providers' usual
676 and customary charge to the general public. The division shall
677 allow ten (10) prescriptions per month for noninstitutionalized
678 Medicaid recipients.

679 Payment for other covered drugs, other than multiple source
680 drugs with HCFA upper limits, shall not exceed the lower of the
681 estimated acquisition cost as determined by the division plus a
682 dispensing fee of Four Dollars and Ninety-one Cents ($4.91) or the
683 providers' usual and customary charge to the general public.

684 Payment for nonlegend or over-the-counter drugs covered on
685 the division's formulary shall be reimbursed at the lower of the
686 division's estimated shelf price or the providers' usual and
687 customary charge to the general public. No dispensing fee shall
688 be paid.

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

693 As used in this paragraph (9), "estimated acquisition cost"
694 means the division's best estimate of what price providers
695 generally are paying for a drug in the package size that providers
696 buy most frequently. Product selection shall be made in
697 compliance with existing state law; however, the division may
698 reimburse as if the prescription had been filled under the generic
699 name. The division may provide otherwise in the case of specified

700 drugs when the consensus of competent medical advice is that
701 trademarked drugs are substantially more effective.
702 (10) Dental care that is an adjunct to treatment of an
703 acute medical or surgical condition; services of oral surgeons and
704 dentists in connection with surgery related to the jaw or any
705 structure contiguous to the jaw or the reduction of any fracture
706 of the jaw or any facial bone; and emergency dental extractions
707 and treatment related thereto. On July 1, 1999, all fees for
708 dental care and surgery under authority of this paragraph (10)
709 shall be increased to one hundred sixty percent (160%) of the
710 amount of the reimbursement rate that was in effect on June 30,
711 1999. It is the intent of the Legislature to encourage more
712 dentists to participate in the Medicaid program.
713 (11) Eyeglasses necessitated by reason of eye surgery,
714 and as prescribed by a physician skilled in diseases of the eye or
715 an optometrist, whichever the patient may select, or one (1) pair
716 every three (3) years as prescribed by a physician or an
717 optometrist, whichever the patient may select.
718 (12) Intermediate care facility services.
719 (a) The division shall make full payment to all
720 intermediate care facilities for the mentally retarded for each
721 day, not exceeding eighty-four (84) days per year, that a patient
722 is absent from the facility on home leave. Payment may be made
723 for the following home leave days in addition to the
724 eighty-four-day limitation: Christmas, the day before Christmas,
725 the day after Christmas, Thanksgiving, the day before Thanksgiving
726 and the day after Thanksgiving.
727 (b) All state-owned intermediate care facilities
728 for the mentally retarded shall be reimbursed on a full reasonable
729 cost basis.
730 (13) Family planning services, including drugs,
731 supplies and devices, when such services are under the supervision
732 of a physician.

733 (14) Clinic services. Such diagnostic, preventive,
734 therapeutic, rehabilitative or palliative services furnished to an
735 outpatient by or under the supervision of a physician or dentist
736 in a facility which is not a part of a hospital but which is
737 organized and operated to provide medical care to outpatients.
738 Clinic services shall include any services reimbursed as
739 outpatient hospital services which may be rendered in such a
740 facility, including those that become so after July 1, 1991. On
741 July 1, 1999, all fees for physicians' services reimbursed under
742 authority of this paragraph (14) shall be reimbursed at ninety
743 percent (90%) of the rate established on January 1, 1999, and as
744 adjusted each January thereafter, under Medicare (Title XVIII of
745 the Social Security Act, as amended), and which shall in no event
746 be less than seventy percent (70%) of the rate established on
747 January 1, 1994. All fees for physicians' services that are
748 covered by both Medicare and Medicaid shall be reimbursed at ten
749 percent (10%) of the adjusted Medicare payment established on
750 January 1, 1999, and as adjusted each January thereafter, under
751 Medicare (Title XVIII of the Social Security Act, as amended), and
752 which shall in no event be less than seventy percent (70%) of the
753 adjusted Medicare payment established on January 1, 1994. On July
754 1, 1999, all fees for dentists' services reimbursed under
755 authority of this paragraph (14) shall be increased to one hundred
756 sixty percent (160%) of the amount of the reimbursement rate that
757 was in effect on June 30, 1999.
758 (15) Home- and community-based services, as provided
759 under Title XIX of the federal Social Security Act, as amended,
760 under waivers, subject to the availability of funds specifically
761 appropriated therefor by the Legislature. Payment for such
762 services shall be limited to individuals who would be eligible for
763 and would otherwise require the level of care provided in a
764 nursing facility. The home- and community-based services
765 authorized under this paragraph shall be expanded over a five-year

766 period beginning July 1, 1999. The division shall certify case
767 management agencies to provide case management services and
768 provide for home- and community-based services for eligible
769 individuals under this paragraph. The home- and community-based
770 services under this paragraph and the activities performed by
771 certified case management agencies under this paragraph shall be
772 funded using state funds that are provided from the appropriation
773 to the Division of Medicaid and used to match federal funds.
774 (16) Mental health services. Approved therapeutic and
775 case management services provided by (a) an approved regional
776 mental health/retardation center established under Sections
777 41-19-31 through 41-19-39, or by another community mental health
778 service provider meeting the requirements of the Department of
779 Mental Health to be an approved mental health/retardation center
780 if determined necessary by the Department of Mental Health, using
781 state funds which are provided from the appropriation to the State
782 Department of Mental Health and used to match federal funds under
783 a cooperative agreement between the division and the department,
784 or (b) a facility which is certified by the State Department of
785 Mental Health to provide therapeutic and case management services,
786 to be reimbursed on a fee for service basis. Any such services
787 provided by a facility described in paragraph (b) must have the
788 prior approval of the division to be reimbursable under this
789 section. After June 30, 1997, mental health services provided by
790 regional mental health/retardation centers established under
791 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
792 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
793 psychiatric residential treatment facilities as defined in Section
794 43-11-1, or by another community mental health service provider
795 meeting the requirements of the Department of Mental Health to be
796 an approved mental health/retardation center if determined
797 necessary by the Department of Mental Health, shall not be

798 included in or provided under any capitated managed care pilot
799 program provided for under paragraph (24) of this section.
800 (17) Durable medical equipment services and medical
801 supplies. Precertification of durable medical equipment and
802 medical supplies must be obtained as required by the division.
803 The Division of Medicaid may require durable medical equipment
804 providers to obtain a surety bond in the amount and to the
805 specifications as established by the Balanced Budget Act of 1997.
806 (18) (a) Notwithstanding any other provision of this
807 section to the contrary, the division shall make additional
808 reimbursement to hospitals which serve a disproportionate share of
809 low-income patients and which meet the federal requirements for
810 such payments as provided in Section 1923 of the federal Social
811 Security Act and any applicable regulations. However, from and
812 after January 1, 2000, no public hospital shall participate in the
813 Medicaid disproportionate share program unless the public hospital
814 participates in an intergovernmental transfer program as provided
815 in Section 1903 of the federal Social Security Act and any
816 applicable regulations. Administration and support for
817 participating hospitals shall be provided by the Mississippi
818 Hospital Association.
819 (b) The division shall establish a Medicare Upper
820 Payment Limits Program as defined in Section 1902 (a) (30) of the
821 federal Social Security Act and any applicable federal
822 regulations. The division shall assess each hospital for the sole
823 purpose of financing the state portion of the Medicare Upper
824 Payment Limits Program. This assessment shall be based on
825 Medicaid utilization, or other appropriate method consistent with
826 federal regulations, and will remain in effect as long as the
827 state participates in the Medicare Upper Payment Limits Program.
828 The division shall make additional reimbursement to hospitals for
829 the Medicare Upper Payment Limits as defined in Section 1902 (a)
830 (30) of the federal Social Security Act and any applicable federal

831 regulations. This paragraph (b) shall stand repealed from and
832 after July 1, 2005.
833 (c) The division shall contract with the
834 Mississippi Hospital Association to provide administrative support
835 for the operation of the disproportionate share hospital program
836 and the Medicare Upper Payment Limits Program. This paragraph (c)
837 shall stand repealed from and after July 1, 2005.
838 (d) The Division of Medicaid shall reimburse
839 Critical Access Hospitals at the Medicare reimbursement rate for
840 eligible inpatient and outpatient services.
841 (19) (a) Perinatal risk management services. The
842 division shall promulgate regulations to be effective from and
843 after October 1, 1988, to establish a comprehensive perinatal
844 system for risk assessment of all pregnant and infant Medicaid
845 recipients and for management, education and follow-up for those
846 who are determined to be at risk. Services to be performed
847 include case management, nutrition assessment/counseling,
848 psychosocial assessment/counseling and health education. The
849 division shall set reimbursement rates for providers in
850 conjunction with the State Department of Health.
851 (b) Early intervention system services. The
852 division shall cooperate with the State Department of Health,
853 acting as lead agency, in the development and implementation of a
854 statewide system of delivery of early intervention services,
855 pursuant to Part H of the Individuals with Disabilities Education
856 Act (IDEA). The State Department of Health shall certify annually
857 in writing to the director of the division the dollar amount of
858 state early intervention funds available which shall be utilized
859 as a certified match for Medicaid matching funds. Those funds
860 then shall be used to provide expanded targeted case management
861 services for Medicaid eligible children with special needs who are
862 eligible for the state's early intervention system.
863 Qualifications for persons providing service coordination shall be

864 determined by the State Department of Health and the Division of
865 Medicaid.
866 (20) Home- and community-based services for physically
867 disabled approved services as allowed by a waiver from the United
868 States Department of Health and Human Services for home- and
869 community-based services for physically disabled people using
870 state funds which are provided from the appropriation to the State
871 Department of Rehabilitation Services and used to match federal
872 funds under a cooperative agreement between the division and the
873 department, provided that funds for these services are
874 specifically appropriated to the Department of Rehabilitation
875 Services.
876 (21) Nurse practitioner services. Services furnished
877 by a registered nurse who is licensed and certified by the
878 Mississippi Board of Nursing as a nurse practitioner including,
879 but not limited to, nurse anesthetists, nurse midwives, family
880 nurse practitioners, family planning nurse practitioners,
881 pediatric nurse practitioners, obstetrics-gynecology nurse
882 practitioners and neonatal nurse practitioners, under regulations
883 adopted by the division. Reimbursement for such services shall
884 not exceed ninety percent (90%) of the reimbursement rate for
885 comparable services rendered by a physician.
886 (22) Ambulatory services delivered in federally
887 qualified health centers and in clinics of the local health
888 departments of the State Department of Health for individuals
889 eligible for medical assistance under this article based on
890 reasonable costs as determined by the division.
891 (23) Inpatient psychiatric services. Inpatient
892 psychiatric services to be determined by the division for
893 recipients under age twenty-one (21) which are provided under the
894 direction of a physician in an inpatient program in a licensed
895 acute care psychiatric facility or in a licensed psychiatric
896 residential treatment facility, before the recipient reaches age

897 twenty-one (21) or, if the recipient was receiving the services
898 immediately before he reached age twenty-one (21), before the
899 earlier of the date he no longer requires the services or the date
900 he reaches age twenty-two (22), as provided by federal
901 regulations. Precertification of inpatient days and residential
902 treatment days must be obtained as required by the division.
903 (24) Managed care services in a program to be developed
904 by the division by a public or private provider. If managed care
905 services are provided by the division to Medicaid recipients, and
906 those managed care services are operated, managed and controlled
907 by and under the authority of the division, the division shall be
908 responsible for educating the Medicaid recipients who are
909 participants in the managed care program regarding the manner in
910 which the participants should seek health care under the program.
911 Notwithstanding any other provision in this article to the
912 contrary, the division shall establish rates of reimbursement to
913 providers rendering care and services authorized under this
914 paragraph (24), and may revise such rates of reimbursement without
915 amendment to this section by the Legislature for the purpose of
916 achieving effective and accessible health services, and for
917 responsible containment of costs.
918 (25) Birthing center services.
919 (26) Hospice care. As used in this paragraph, the term
920 "hospice care" means a coordinated program of active professional
921 medical attention within the home and outpatient and inpatient
922 care which treats the terminally ill patient and family as a unit,
923 employing a medically directed interdisciplinary team. The
924 program provides relief of severe pain or other physical symptoms
925 and supportive care to meet the special needs arising out of
926 physical, psychological, spiritual, social and economic stresses
927 which are experienced during the final stages of illness and
928 during dying and bereavement and meets the Medicare requirements
929 for participation as a hospice as provided in federal regulations.

930 (27) Group health plan premiums and cost sharing if it
931 is cost effective as defined by the Secretary of Health and Human
932 Services.
933 (28) Other health insurance premiums which are cost
934 effective as defined by the Secretary of Health and Human
935 Services. Medicare eligible must have Medicare Part B before
936 other insurance premiums can be paid.
937 (29) The Division of Medicaid may apply for a waiver
938 from the Department of Health and Human Services for home- and
939 community-based services for developmentally disabled people using
940 state funds which are provided from the appropriation to the State
941 Department of Mental Health and used to match federal funds under
942 a cooperative agreement between the division and the department,
943 provided that funds for these services are specifically
944 appropriated to the Department of Mental Health.
945 (30) Pediatric skilled nursing services for eligible
946 persons under twenty-one (21) years of age.
947 (31) Targeted case management services for children
948 with special needs, under waivers from the United States
949 Department of Health and Human Services, using state funds that
950 are provided from the appropriation to the Mississippi Department
951 of Human Services and used to match federal funds under a
952 cooperative agreement between the division and the department.
953 (32) Care and services provided in Christian Science
954 Sanatoria operated by or listed and certified by The First Church
955 of Christ Scientist, Boston, Massachusetts, rendered in connection
956 with treatment by prayer or spiritual means to the extent that
957 such services are subject to reimbursement under Section 1903 of
958 the Social Security Act.
959 (33) Podiatrist services.
960 (34) The division shall make application to the United
961 States Health Care Financing Administration for a waiver to
962 develop a program of services to personal care and assisted living

963 homes in Mississippi. This waiver shall be completed by December
964 1, 1999.
965 (35) Services and activities authorized in Sections
966 43-27-101 and 43-27-103, using state funds that are provided from
967 the appropriation to the State Department of Human Services and
968 used to match federal funds under a cooperative agreement between
969 the division and the department.
970 (36) Nonemergency transportation services for
971 Medicaid-eligible persons, to be provided by the Division of
972 Medicaid. The division may contract with additional entities to
973 administer nonemergency transportation services as it deems
974 necessary. All providers shall have a valid driver's license,
975 vehicle inspection sticker, valid vehicle license tags and a
976 standard liability insurance policy covering the vehicle.
977 (37) [Deleted]
978 (38) Chiropractic services: a chiropractor's manual
979 manipulation of the spine to correct a subluxation, if x-ray
980 demonstrates that a subluxation exists and if the subluxation has
981 resulted in a neuromusculoskeletal condition for which
982 manipulation is appropriate treatment. Reimbursement for
983 chiropractic services shall not exceed Seven Hundred Dollars
984 ($700.00) per year per recipient.
985 (39) Dually eligible Medicare/Medicaid beneficiaries.
986 The division shall pay the Medicare deductible and ten percent
987 (10%) coinsurance amounts for services available under Medicare
988 for the duration and scope of services otherwise available under
989 the Medicaid program.
990 (40) [Deleted]
991 (41) Services provided by the State Department of
992 Rehabilitation Services for the care and rehabilitation of persons
993 with spinal cord injuries or traumatic brain injuries, as allowed
994 under waivers from the United States Department of Health and
995 Human Services, using up to seventy-five percent (75%) of the

996 funds that are appropriated to the Department of Rehabilitation
997 Services from the Spinal Cord and Head Injury Trust Fund
998 established under Section 37-33-261 and used to match federal
999 funds under a cooperative agreement between the division and the
1000 department.

1001 (42) Notwithstanding any other provision in this
1002 article to the contrary, the division is hereby authorized to
1003 develop a population health management program for women and
1004 children health services through the age of two (2). This program
1005 is primarily for obstetrical care associated with low birth weight
1006 and pre-term babies. In order to effect cost savings, the
1007 division may develop a revised payment methodology which may
1008 include at-risk capitated payments.

1009 (43) The division shall provide reimbursement,
1010 according to a payment schedule developed by the division, for
1011 smoking cessation medications for pregnant women during their
1012 pregnancy and other Medicaid-eligible women who are of
1013 child-bearing age.

1014 (44) Nursing facility services for the severely
1015 disabled.

1016 (a) Severe disabilities include, but are not
1017 limited to, spinal cord injuries, closed head injuries and
1018 ventilator dependent patients.

1019 (b) Those services must be provided in a long-term
1020 care nursing facility dedicated to the care and treatment of
1021 persons with severe disabilities, and shall be reimbursed as a
1022 separate category of nursing facilities.

1023 (45) Physician assistant services. Services furnished
1024 by a physician assistant who is licensed by the State Board of
1025 Medical Licensure and is practicing with physician supervision
1026 under regulations adopted by the board, under regulations adopted
1027 by the division. Reimbursement for those services shall not

1028 exceed ninety percent (90%) of the reimbursement rate for
1029 comparable services rendered by a physician.
1030 (46) The division shall make application to the federal
1031 Health Care Financing Administration for a waiver to develop and
1032 provide services for children with serious emotional disturbances
1033 as defined in Section 43-14-1(1), which may include home- and
1034 community-based services, case management services or managed care
1035 services through mental health providers certified by the
1036 Department of Mental Health. The division may implement and
1037 provide services under this waivered program only if funds for
1038 these services are specifically appropriated for this purpose by
1039 the Legislature, or if funds are voluntarily provided by affected
1040 agencies.
1041 (47) The division shall make application to the
1042 Secretary of Health and Human Services for a federal 1115 waiver
1043 of the applicable provisions of Title XIX of the federal Social
1044 Security Act, as amended, and any other applicable provisions of
1045 federal law as necessary to develop and provide school nurse
1046 services authorized under Section 41-79-5, Mississippi Code of
1047 1972, for any compulsory-school-age child attending a public
1048 school in Mississippi. Any state agency which on July 1, 2002, is
1049 providing funds for a school nurse intervention program, is hereby
1050 directed to deposit any such state funds with the Division of
1051 Medicaid to establish a pool of funds which shall be available for
1052 increasing the present funding levels of school nurses by matching
1053 Medicaid funds with federal funds. The division shall provide
1054 school nurse services to school districts based on a school nurse
1055 to student attendance population ratio of 1/750. School nurse
1056 services provided under this paragraph (47) shall be phased-in
1057 statewide as funds become available for this purpose. The
1058 division may implement and provide school nurse services under
1059 this waivered program only if funds for these services are

1060 specifically appropriated for this purpose by the Legislature or
1061 if funds are voluntarily provided by the affected agencies.
1062 (48) The division shall provide targeted case
1063 management services for beneficiaries who have diagnosis of
1064 diabetes or cardiovascular disease as determined by the division.
1065 Notwithstanding any provision of this article, except as
1066 authorized in the following paragraph and in Section 43-13-139,
1067 neither (a) the limitations on quantity or frequency of use of or
1068 the fees or charges for any of the care or services available to
1069 recipients under this section, nor (b) the payments or rates of
1070 reimbursement to providers rendering care or services authorized
1071 under this section to recipients, may be increased, decreased or
1072 otherwise changed from the levels in effect on July 1, 1999,
1073 unless such is authorized by an amendment to this section by the
1074 Legislature. However, the restriction in this paragraph shall not
1075 prevent the division from changing the payments or rates of
1076 reimbursement to providers without an amendment to this section
1077 whenever such changes are required by federal law or regulation,
1078 or whenever such changes are necessary to correct administrative
1079 errors or omissions in calculating such payments or rates of
1080 reimbursement.
1081 Notwithstanding any provision of this article, no new groups
1082 or categories of recipients and new types of care and services may
1083 be added without enabling legislation from the Mississippi
1084 Legislature, except that the division may authorize such changes
1085 without enabling legislation when such addition of recipients or
1086 services is ordered by a court of proper authority. The director
1087 shall keep the Governor advised on a timely basis of the funds
1088 available for expenditure and the projected expenditures. In the
1089 event current or projected expenditures can be reasonably
1090 anticipated to exceed the amounts appropriated for any fiscal
1091 year, the Governor, after consultation with the director, shall
1092 discontinue any or all of the payment of the types of care and

1093 services as provided herein which are deemed to be optional
1094 services under Title XIX of the federal Social Security Act, as
1095 amended, for any period necessary to not exceed appropriated
1096 funds, and when necessary shall institute any other cost
1097 containment measures on any program or programs authorized under
1098 the article to the extent allowed under the federal law governing
1099 such program or programs, it being the intent of the Legislature
1100 that expenditures during any fiscal year shall not exceed the
1101 amounts appropriated for such fiscal year.

1102 Notwithstanding any other provision of this article, it shall
1103 be the duty of each nursing facility, intermediate care facility
1104 for the mentally retarded, psychiatric residential treatment
1105 facility, and nursing facility for the severely disabled that is
1106 participating in the medical assistance program to keep and
1107 maintain books, documents, and other records as prescribed by the
1108 Division of Medicaid in substantiation of its cost reports for a
1109 period of three (3) years after the date of submission to the
1110 Division of Medicaid of an original cost report, or three (3)
1111 years after the date of submission to the Division of Medicaid of
1112 an amended cost report.

1113 **SECTION 4.** Section 25-15-9, Mississippi Code of 1972, is
1114 amended as follows:

1115 25-15-9. (1) (a) The board shall design a plan of health
1116 insurance for state employees which provides benefits for
1117 semiprivate rooms in addition to other incidental coverages which
1118 the board deems necessary. The amount of the coverages shall be
1119 in such reasonable amount as may be determined by the board to be
1120 adequate, after due consideration of current health costs in
1121 Mississippi. The plan shall also include major medical benefits
1122 in such amounts as the board shall determine. The board is also
1123 authorized to accept bids for such alternate coverage and optional
1124 benefits as the board shall deem proper. Any contract for
1125 alternative coverage and optional benefits shall be awarded by the

1126 board after it has carefully studied and evaluated the bids and
1127 selected the best and most cost-effective bid. The board may
1128 reject all such bids; however, the board shall notify all bidders
1129 of the rejection and shall actively solicit new bids if all bids
1130 are rejected. The board may employ or contract for such
1131 consulting or actuarial services as may be necessary to formulate
1132 the plan, and to assist the board in the preparation of
1133 specifications and in the process of advertising for the bids for
1134 the plan. Such contracts shall be solicited and entered into in
1135 accordance with Section 25-15-5. The board shall keep a record of
1136 all persons, agents and corporations who contract with or assist
1137 the board in preparing and developing the plan. The board in a
1138 timely manner shall provide copies of this record to the members
1139 of the advisory council created in this section and those
1140 legislators, or their designees, who may attend meetings of the
1141 advisory council. The board shall provide copies of this record
1142 in the solicitation of bids for the administration or servicing of
1143 the self-insured program. Each person, agent or corporation
1144 which, during the previous fiscal year, has assisted in the
1145 development of the plan or employed or compensated any person who
1146 assisted in the development of the plan, and which bids on the
1147 administration or servicing of the plan, shall submit to the board
1148 a statement accompanying the bid explaining in detail its
1149 participation with the development of the plan. This statement
1150 shall include the amount of compensation paid by the bidder to any
1151 such employee during the previous fiscal year. The board shall
1152 make all such information available to the members of the advisory
1153 council and those legislators, or their designees, who may attend
1154 meetings of the advisory council before any action is taken by the
1155 board on the bids submitted. The failure of any bidder to fully
1156 and accurately comply with this paragraph shall result in the
1157 rejection of any bid submitted by that bidder or the cancellation
1158 of any contract executed when the failure is discovered after the

1159 acceptance of that bid. The board is authorized to promulgate
1160 rules and regulations to implement the provisions of this
1161 subsection.

1162 The board shall develop plans for the insurance plan
1163 authorized by this section in accordance with the provisions of
1164 Section 25-15-5.

1165 Any corporation, association, company or individual that
1166 contracts with the board for the third-party claims administration
1167 of the self-insured plan shall prepare and keep on file an
1168 explanation of benefits for each claim processed. The explanation
1169 of benefits shall contain such information relative to each
1170 processed claim which the board deems necessary, and, at a
1171 minimum, each explanation shall provide the claimant's name, claim
1172 number, provider number, provider name, service dates, type of
1173 services, amount of charges, amount allowed to the claimant and
1174 reason codes. The information contained in the explanation of
1175 benefits shall be available for inspection upon request by the
1176 board. The board shall have access to all claims information
1177 utilized in the issuance of payments to employees and providers.

1178 (b) There is created an advisory council to advise the
1179 board in the formulation of the State and School Employees Health
1180 Insurance Plan. The council shall be composed of the State
1181 Insurance Commissioner or his designee, an employee-representative
1182 of the institutions of higher learning appointed by the board of
1183 trustees thereof, an employee-representative of the Department of
1184 Transportation appointed by the director thereof, an
1185 employee-representative of the State Tax Commission appointed by
1186 the Commissioner of Revenue, an employee-representative of the
1187 Mississippi Department of Health appointed by the State Health
1188 Officer, an employee-representative of the Mississippi Department
1189 of Corrections appointed by the Commissioner of Corrections, and
1190 an employee-representative of the Department of Human Services
1191 appointed by the Executive Director of Human Services, two (2)

1192 certificated public school administrators appointed by the State
1193 Board of Education, two (2) certificated classroom teachers
1194 appointed by the State Board of Education, a noncertificated
1195 school employee appointed by the State Board of Education and a
1196 community/junior college employee appointed by the State Board for
1197 Community and Junior Colleges.

1198 The Lieutenant Governor may designate the Secretary of the
1199 Senate, the Chairman of the Senate Appropriations Committee, the
1200 Chairman of the Senate Education Committee and the Chairman of the
1201 Senate Insurance Committee, and the Speaker of the House of
1202 Representatives may designate the Clerk of the House, the Chairman
1203 of the House Appropriations Committee, the Chairman of the House
1204 Education Committee and the Chairman of the House Insurance
1205 Committee, to attend any meeting of the State and School Employees
1206 Insurance Advisory Council. The appointing authorities may
1207 designate an alternate member from their respective houses to
1208 serve when the regular designee is unable to attend such meetings
1209 of the council. Such designees shall have no jurisdiction or vote
1210 on any matter within the jurisdiction of the council. For
1211 attending meetings of the council, such legislators shall receive
1212 per diem and expenses which shall be paid from the contingent
1213 expense funds of their respective houses in the same amounts as
1214 provided for committee meetings when the Legislature is not in
1215 session; however, no per diem and expenses for attending meetings
1216 of the council will be paid while the Legislature is in session.
1217 No per diem and expenses will be paid except for attending
1218 meetings of the council without prior approval of the proper
1219 committee in their respective houses.

1220 (c) No change in the terms of the State and School
1221 Employees Health Insurance Plan may be made effective unless the
1222 board, or its designee, has provided notice to the State and
1223 School Employees Health Insurance Advisory Council and has called
1224 a meeting of the council at least fifteen (15) days before the

1225 effective date of such change. In the event that the State and
1226 School Employees Health Insurance Advisory Council does not meet
1227 to advise the board on the proposed changes, the changes to the
1228 plan shall become effective at such time as the board has informed
1229 the council that the changes shall become effective.
1230 (d) **Medical benefits for retired employees and**
1231 **dependents under age sixty-five (65) years and not eligible for**
1232 **Medicare benefits**. The same health insurance coverage as for all
1233 other active employees and their dependents shall be available to
1234 retired employees and all dependents under age sixty-five (65)
1235 years who are not eligible for Medicare benefits, the level of
1236 benefits to be the same level as for all other active
1237 participants. This section will apply to those employees who
1238 retire due to one hundred percent (100%) medical disability as
1239 well as those employees electing early retirement.
1240 (e) **Medical benefits for retired employees and**
1241 **dependents over age sixty-five (65) years or otherwise eligible**
1242 **for Medicare benefits.** The health insurance coverage available to
1243 retired employees over age sixty-five (65) years or otherwise
1244 eligible for Medicare benefits, and all dependents over age
1245 sixty-five (65) years or otherwise eligible for Medicare benefits,
1246 shall be the major medical coverage with the lifetime maximum of
1247 One Million Dollars ($1,000,000.00). Benefits shall be reduced by
1248 Medicare benefits as though such Medicare benefits were the base
1249 plan.
1250 All covered individuals shall be assumed to have full
1251 Medicare coverage, Parts A and B; and any Medicare payments under
1252 both Parts A and B shall be computed to reduce benefits payable
1253 under this plan.
1254 (2) Nonduplication of benefits--reduction of benefits by
1255 Title XIX benefits: When benefits would be payable under more
1256 than one (1) group plan, benefits under those plans will be

1257 coordinated to the extent that the total benefits under all plans
1258 will not exceed the total expenses incurred.
1259 Benefits for hospital or surgical or medical benefits shall
1260 be reduced by any similar benefits payable in accordance with
1261 Title XIX of the Social Security Act or under any amendments
1262 thereto, or any implementing legislation.
1263 Benefits for hospital or surgical or medical benefits shall
1264 be reduced by any similar benefits payable by workers'
1265 compensation.
1266 (3) (a) Schedule of life insurance benefits--group term:
1267 The amount of term life insurance for each active employee of a
1268 department, agency or institution of the state government shall
1269 not be in excess of One Hundred Thousand Dollars ($100,000.00), or
1270 twice the amount of the employee's annual wage to the next highest
1271 One Thousand Dollars ($1,000.00), whichever may be less, but in no
1272 case less than Thirty Thousand Dollars ($30,000.00), with a like
1273 amount for accidental death and dismemberment on a
1274 twenty-four-hour basis. The plan will further contain a premium
1275 waiver provision if a covered employee becomes totally and
1276 permanently disabled prior to age sixty-five (65) years.
1277 Employees retiring after June 30, 1999, shall be eligible to
1278 continue life insurance coverage in an amount of Five Thousand
1279 Dollars ($5,000.00), Ten Thousand Dollars ($10,000.00) or Twenty
1280 Thousand Dollars ($20,000.00) into retirement.
1281 (b) Effective October 1, 1999, schedule of life
1282 insurance benefits--group term: The amount of term life insurance
1283 for each active employee of any school district, community/junior
1284 college, public library or university-based program authorized
1285 under Section 37-23-31 for deaf, aphasic and emotionally disturbed
1286 children or any regular nonstudent bus driver shall not be in
1287 excess of One Hundred Thousand Dollars ($100,000.00), or twice the
1288 amount of the employee's annual wage to the next highest One
1289 Thousand Dollars ($1,000.00), whichever may be less, but in no

1290 case less than Thirty Thousand Dollars ($30,000.00), with a like
1291 amount for accidental death and dismemberment on a
1292 twenty-four-hour basis. The plan will further contain a premium
1293 waiver provision if a covered employee of any school district,
1294 community/junior college, public library or university-based
1295 program authorized under Section 37-23-31 for deaf, aphasic and
1296 emotionally disturbed children or any regular nonstudent bus
1297 driver becomes totally and permanently disabled prior to age
1298 sixty-five (65) years. Employees of any school district,
1299 community/junior college, public library or university-based
1300 program authorized under Section 37-23-31 for deaf, aphasic and
1301 emotionally disturbed children or any regular nonstudent bus
1302 driver retiring after September 30, 1999, shall be eligible to
1303 continue life insurance coverage in an amount of Five Thousand
1304 Dollars ($5,000.00), Ten Thousand Dollars ($10,000.00) or Twenty
1305 Thousand Dollars ($20,000.00) into retirement.
1306 (4) Any eligible employee who on March 1, 1971, was
1307 participating in a group life insurance program which has
1308 provisions different from those included herein and for which the
1309 State of Mississippi was paying a part of the premium may, at his
1310 discretion, continue to participate in such plan. Such employee
1311 shall pay in full all additional costs, if any, above the minimum
1312 program established by this article. Under no circumstances shall
1313 any individual who begins employment with the state after March 1,
1314 1971, be eligible for the provisions of this paragraph.
1315 (5) The board may offer medical savings accounts as defined
1316 in Section 71-9-3 as a plan option.
1317 (6) Any premium differentials, differences in coverages,
1318 discounts determined by risk or by any other factors shall be
1319 uniformly applied to all active employees participating in the
1320 insurance plan. It is the intent of the Legislature that the
1321 state contribution to the plan be the same for each employee
1322 throughout the state.

1323 (7) On October 1, 1999, any school district,
1324 community/junior college district or public library may elect to
1325 remain with an existing policy or policies of group life insurance
1326 with an insurance company approved by the State and School
1327 Employees Health Insurance Management Board, in lieu of
1328 participation in the State and School Life Insurance Plan. The
1329 state's contribution of up to fifty percent (50%) of the active
1330 employee's premium under the State and School Life Insurance Plan
1331 may be applied toward the cost of coverage for full-time employees
1332 participating in the approved life insurance company group plan.
1333 For purposes of this subsection (7), "life insurance company group
1334 plan" means a plan administered or sold by a private insurance
1335 company. After October 1, 1999, the board may assess charges in
1336 addition to the existing State and School Life Insurance Plan
1337 rates to such employees as a condition of enrollment in the State
1338 and School Life Insurance Plan. In order for any life insurance
1339 company group plan existing as of October 1, 1999, to be approved
1340 by the State and School Employees Health Insurance Management
1341 Board under this subsection (7), it shall meet the following
1342 criteria:
1343 (a) The insurance company offering the group life
1344 insurance plan shall be rated "A-" or better by A.M. Best state
1345 insurance rating service and be licensed as an admitted carrier in
1346 the State of Mississippi by the Mississippi Department of
1347 Insurance.
1348 (b) The insurance company group life insurance plan
1349 shall provide the same life insurance, accidental death and
1350 dismemberment insurance and waiver of premium benefits as provided
1351 in the State and School Life Insurance Plan.
1352 (c) The insurance company group life insurance plan
1353 shall be fully insured, and no form of self-funding life insurance
1354 by such company shall be approved.

1355 (d) The insurance company group life insurance plan
1356 shall have one (1) composite rate per One Thousand Dollars
1357 ($1,000.00) of coverage for active employees regardless of age and
1358 one (1) composite rate per One Thousand Dollars ($1,000.00) of
1359 coverage for all retirees regardless of age or type of retiree.
1360 (e) The insurance company and its group life insurance
1361 plan shall comply with any administrative requirements of the
1362 State and School Employees Health Insurance Management Board. In
1363 the event any insurance company providing group life insurance
1364 benefits to employees under this subsection (7) fails to comply
1365 with any requirements specified herein or any administrative
1366 requirements of the board, the state shall discontinue providing
1367 funding for the cost of such insurance.
1368 (8) On or after July 1, 2002, the State and School Employees
1369 Health Insurance Management Board is authorized and directed to
1370 revise the state health plan to enhance employee and dependent
1371 coverage benefits as follows: (a) eliminate the deductible amount
1372 for a network physician office visit by the employee or a
1373 dependent; (b) institute a co-payment requirement for the
1374 physician visit of Fifteen Dollars ($15.00) for a primary care
1375 physician visit and Twenty-five Dollars ($25.00) for a specialist
1376 visit; (c) apply a twenty percent (20%) co-insurance requirement
1377 for other services provided in the physician's office or clinic
1378 which are not subject to the deductible.
1379 **SECTION 5.** (1) There is established the Mississippi Access
1380 to Care (MAC) Oversight Committee to coordinate the
1381 implementation, funding and any needed revisions of the MAC plan
1382 dated September 30, 2001, that was prepared and submitted to the
1383 Legislature as required under Sections 43-57-1 through 43-57-9.
1384 (2) The MAC Oversight Committee shall be composed of:
1385 (a) Six (6) members appointed by the Governor, at least
1386 five (5) of whom must be persons with disabilities;
1387 (b) Four (4) members appointed by the Lieutenant

1388 Governor, at least three (3) of whom must be persons with
1389 disabilities;
1390 (c) The executive directors of the Department of Mental
1391 Health, the State Department of Rehabilitation Services, the
1392 Department of Human Services and the Division of Medicaid, or
1393 their designees;
1394 (d) A representative of the Governor's office;
1395 (e) The Chairs and Vice Chairs of the Public Health and
1396 Welfare Committee and the Appropriations Committee of the House of
1397 Representatives, as nonvoting members; and
1398 (f) The Chairs and Vice Chairs of the Public Health and
1399 Welfare Committee and the Appropriations Committee of the Senate,
1400 as nonvoting members.
1401 (3) (a) Of the Governor's appointments, one (1) member
1402 shall be appointed from each congressional district as constituted
1403 on July 1, 2002, and two (2) members shall be appointed from the
1404 state at large. The initial appointments of the Governor shall be
1405 made as follows: one (1) member shall be appointed for a term
1406 ending on June 30, 2003, two (2) members shall be appointed for
1407 terms ending on June 30, 2004, one (1) member shall be appointed
1408 for a term ending on June 30, 2005, and two (2) members shall be
1409 appointed for terms ending on June 30, 2006. All subsequent
1410 appointments shall be for terms of four (4) years from the
1411 expiration date of the previous term. Any vacancy before the
1412 expiration of a term shall be filled by appointment of the
1413 Governor, and the person appointed to fill the vacancy shall serve
1414 for the remainder of the unexpired term.
1415 (b) Of the Lieutenant Governor's appointments, one (1)
1416 member shall be appointed from each congressional district as
1417 constituted on July 1, 2002. The initial appointments of the
1418 Lieutenant Governor shall be made as follows: one (1) member
1419 shall be appointed for a term ending on June 30, 2003, one (1)
1420 member shall be appointed for a term ending on June 30, 2004, one

1421 (1) member shall be appointed for a term ending on June 30, 2005,
1422 and one (1) member shall be appointed for a term ending on June
1423 30, 2006. All subsequent appointments shall be for terms of four
1424 (4) years from the expiration date of the previous term. Any
1425 vacancy before the expiration of a term shall be filled by
1426 appointment of the Lieutenant Governor, and the person appointed
1427 to fill the vacancy shall serve for the remainder of the unexpired
1428 term.

1429 (3) At the first meeting of the committee, the members shall
1430 select one (1) member to serve as chair of the committee. The
1431 committee shall select a chair once every two (2) years, and any
1432 person who has previously served as chair may be reelected as
1433 chair.

1434 (4) Eight (8) of the voting members of the committee shall
1435 constitute a quorum for the transaction of any business of the
1436 committee. The committee shall meet at least once each quarter,
1437 and may meet at other times as necessary for the purpose of
1438 conducting any business that may be required. All meetings shall
1439 be called by the chair or by a majority of the voting members of
1440 the committee, except the first meeting, which shall be called by
1441 the Governor.

1442 (5) The appointed members and the legislative members of the
1443 committee shall receive a per diem in the amount provided under
1444 Section 25-3-69 for each day engaged in the official business of
1445 the committee. The appointed members of the committee other than
1446 the legislative members shall receive reimbursement for travel
1447 expenses incurred while engaged in official business of the
1448 committee in accordance with Section 25-3-41, and the legislative
1449 members of the committee shall receive the expense allowance
1450 provided for in Section 5-1-47. However, the legislative members
1451 of the committee shall not receive the per diem or expense
1452 allowance for any day that the committee meets while the
1453 Legislature is in session.

1454 **SECTION 6.** (1) The MAC Oversight Committee is ultimately
1455 responsible for implementation of the MAC plan. The committee
1456 shall continually review and assess the three-part test for states
1457 and the three (3) risk zones for states to fulfill the state's
1458 obligation to:
1459 (a) Divert persons from initially being placed into
1460 institutions;
1461 (b) Review those persons already in institutions to
1462 determine how many could be and want to be served in a home- and
1463 community-based setting; and
1464 (c) Respond to individual requests by institutionalized
1465 persons to leave the institutional setting to go to a home- and
1466 community-based setting.
1467 (2) The duties of the MAC Oversight Committee are to:
1468 (a) Identify, collect, and disburse data regarding the
1469 number and status of persons with disabilities and the
1470 availability and quality of community services and supports;
1471 (b) Monitor the development and expansion of community
1472 services and the movement on the waiting list;
1473 (c) Actively and continuously review and recommend
1474 modifications to the MAC plan;
1475 (d) Provide persons with disabilities a process for
1476 independent review and appeal of decisions made by treating
1477 professionals;
1478 (e) Develop the specific criteria and tools to measure
1479 the effectiveness of the MAC plan strategies, submit them to the
1480 responsible agency or agencies for concurrence, and make an annual
1481 report to the Legislature of the outcomes;
1482 (f) Hold periodic public meetings to provide
1483 information and opportunities for input;
1484 (g) In conjunction with the Governor's Commission on
1485 Disability, establish a single point of intake for persons with

1486 disabilities to provide an independent identifying, screening and
1487 referring process;
1488 (h) Identify specific steps for the provision of a
1489 comprehensive system of support services to persons once they are
1490 identified; and
1491 (i) Establish a baseline for the existing waiting time
1492 for each service, define what constitutes a "reasonable pace" for
1493 providing community services, and design and implement a plan to
1494 move from the current waiting time to a time that is "reasonable."
1495 **SECTION 7.** (1) In implementing the MAC plan, the Department
1496 of Mental Health, the State Department of Rehabilitation Services,
1497 the Department of Human Services, the State Department of
1498 Education and the Division of Medicaid each shall:
1499 (a) Develop and maintain an ongoing, comprehensive data
1500 collection system for identifying persons with disabilities who
1501 are receiving or are in need of services and supports from that
1502 agency;
1503 (b) Develop and implement a comprehensive evaluation
1504 procedure ensuring that, where appropriate, each person with
1505 disabilities and/or the person's guardian will be involved in the
1506 assessment and planning process and that the assessment will be
1507 directed toward providing services in the "least restricted, most
1508 integrated setting possible" based upon professional
1509 recommendations and the choice of the person and his or her
1510 family; and
1511 (c) Provide to the MAC Oversight Committee with reports
1512 specifying the agency's budgetary and program implementation
1513 response to the MAC plan. Each agency shall provide the reports
1514 to the committee at least twice annually, and at other times as
1515 required by the committee.
1516 (i) The first report required by this paragraph
1517 shall be provided to the committee after the development of the
1518 agency's budget and before the beginning of the Joint Legislative

1519 Budget Committee's hearings on agency budget requests in the fall
1520 of the year. That report shall detail the portions of the
1521 agency's budget request that would be directed toward the
1522 implementation of the MAC plan, including the number of citizens
1523 to be served and the specific services to be provided, the amount
1524 of money required to provide the services and the source of the
1525 funding.
1526 (ii) The second report required by this paragraph
1527 shall be provided to the committee not later than thirty (30) days
1528 after the end of the regular session of the Legislature. That
1529 report shall include the same information as in the first report,
1530 except that it shall detail the portions of the agency's proposed
1531 budget that the Legislature funded. The second report also shall
1532 include a more detailed narrative of the services that must be
1533 carried forward to the next budgetary cycle and the services that
1534 require amendment due to the funding that was made available.
1535 **SECTION 8.** In implementing the MAC plan, the MAC Oversight
1536 Committee shall:
1537 (a) Establish a consumer friendly, single point of
1538 entry referral system for persons with disabilities who need
1539 assistance identifying and/or accessing appropriate and desired
1540 services, and an evaluation/assessment procedure working in
1541 together with the referral system;
1542 (b) Identify those persons with disabilities currently
1543 in nursing facilities, advise them of the home- and
1544 community-based alternatives available and allow them the option
1545 to choose the most integrated setting of their choice; and
1546 (c) Act as the lead agency responsible for developing
1547 and coordinating a comprehensive housing plan for persons with all
1548 types of disabilities. The plan shall address the following
1549 components:
1550 (i) Identification of persons with disabilities
1551 needing or wanting community-based housing;

1552 (ii) Support services needed by persons with
1553 disabilities to live independently;
1554 (iii) Funding assistance for housing.
1555 (d) Act as the lead entity responsible for developing
1556 and implementing a comprehensive transportation plan for all
1557 persons with disabilities that will maximize existing resources
1558 and develop future funding requests;
1559 (e) Establish creative transportation initiatives and
1560 demonstration projects;
1561 (f) Develop a transportation guide for all persons with
1562 disabilities; and
1563 (g) Perform a feasibility study in fiscal year 2004 to
1564 determine options for an interagency, consolidated transportation
1565 plan.
1566 **SECTION 9.** Section 41-79-5, Mississippi Code of 1972, is
1567 amended as follows:
1568 41-79-5. (1) There is hereby established within the State
1569 Department of Health a school nurse intervention program,
1570 available to all public school districts in the state.
1571 (2) By the school year 1998-1999, each public school
1572 district shall have employed a school nurse, to be known as a
1573 Health Service Coordinator, pursuant to the school nurse
1574 intervention program prescribed under this section. The school
1575 nurse intervention program shall offer any of the following
1576 specific preventive services, and other additional services
1577 appropriate to each grade level and the age and maturity of the
1578 pupils:
1579 (a) Reproductive health education and referral to
1580 prevent teen pregnancy and sexually transmitted diseases, which
1581 education shall include abstinence;
1582 (b) Child abuse and neglect identification;

1583 (c) Hearing and vision screening to detect problems
1584 which can lead to serious sensory losses and behavioral and
1585 academic problems;
1586 (d) Alcohol, tobacco and drug abuse education to reduce
1587 abuse of these substances;
1588 (e) Scoliosis screening to detect this condition so
1589 that costly and painful surgery and lifelong disability can be
1590 prevented;
1591 (f) Coordination of services for handicapped children
1592 to ensure that these children receive appropriate medical
1593 assistance and are able to remain in public school;
1594 (g) Nutrition education and counseling to prevent
1595 obesity and/or other eating disorders which may lead to
1596 life-threatening conditions, for example, hypertension;
1597 (h) Early detection and treatment of head lice to
1598 prevent the spread of the parasite and to reduce absenteeism;
1599 (i) Emergency treatment of injury and illness to
1600 include controlling bleeding, managing fractures, bruises or
1601 contusions and cardiopulmonary resuscitation (CPR);
1602 (j) Applying appropriate theory as the basis for
1603 decision making in nursing practice;
1604 (k) Establishing and maintaining a comprehensive school
1605 health program;
1606 (l) Developing individualized health plans;
1607 (m) Assessing, planning, implementing and evaluating
1608 programs and other school health activities, in collaboration with
1609 other professionals;
1610 (n) Providing health education to assist students,
1611 families and groups to achieve optimal levels of wellness;
1612 (o) Participating in peer review and other means of
1613 evaluation to assure quality of nursing care provided for students
1614 and assuming responsibility for continuing education and

1615 professional development for self while contributing to the
1616 professional growth of others;
1617 (p) Participating with other key members of the
1618 community responsible for assessing, planning, implementing and
1619 evaluating school health services and community services that
1620 include the broad continuum or promotion of primary, secondary and
1621 tertiary prevention; and
1622 (q) Contributing to nursing and school health through
1623 innovations in theory and practice and participation in research.
1624 (3) Public school nurses shall be specifically prohibited
1625 from providing abortion counseling to any student or referring any
1626 student to abortion counseling or abortion clinics. Any violation
1627 of this subsection shall disqualify the school district employing
1628 such public school nurse from receiving any state administered
1629 funds under this section.
1630 (4) (Repealed)
1631 (5) Beginning with the 1997-1998 school year, to the extent
1632 that federal or state funds are available therefor and pursuant to
1633 appropriation therefor by the Legislature, in addition to the
1634 school nurse intervention program funds administered under
1635 subsection (4), the State Department of Health shall establish and
1636 implement a Prevention of Teen Pregnancy Pilot Program to be
1637 located in the public school districts with the highest numbers of
1638 teen pregnancies. The Teen Pregnancy Pilot Program shall provide
1639 the following education services directly through public school
1640 nurses in the pilot school districts: health education sessions
1641 in local schools, where contracted for or invited to provide,
1642 which target issues including reproductive health, teen pregnancy
1643 prevention and sexually transmitted diseases, including syphilis,
1644 HIV and AIDS. When these services are provided by a school nurse,
1645 training and counseling on abstinence shall be included.
1646 (6) In addition to the school nurse intervention program
1647 funds administered under subsection (4) and the Teen Pregnancy

1648 Pilot Program funds administered under subsection (5), to the
1649 extent that federal or state funds are available therefor and
1650 pursuant to appropriation therefor by the Legislature, the State
1651 Department of Health shall establish and implement an Abstinence
1652 Education Pilot Program to provide abstinence education,
1653 mentoring, counseling and adult supervision to promote abstinence
1654 from sexual activity, with a focus on those groups which are most
1655 likely to bear children out of wedlock. Such abstinence education
1656 services shall be provided by the State Department of Health
1657 through its clinics, public health nurses, school nurses and
1658 through contracts with rural and community health centers in order
1659 to reach a larger number of targeted clients. For purposes of
1660 this subsection, the term "abstinence education" means an
1661 educational or motivational program which:

1662 (a) Has as its exclusive purpose, teaching the social,
1663 psychological and health gains to be realized by abstaining from
1664 sexual activity;

1665 (b) Teaches abstinence from sexual activity outside
1666 marriage as the expected standard for all school-age children;

1667 (c) Teaches that abstinence from sexual activity is the
1668 only certain way to avoid out-of-wedlock pregnancy, sexually
1669 transmitted diseases and other associated health problems;

1670 (d) Teaches that a mutually faithful monogamous
1671 relationship in context of marriage is the expected standard of
1672 human sexual activity;

1673 (e) Teaches that sexual activity outside of the context
1674 of marriage is likely to have harmful psychological and physical
1675 effects;

1676 (f) Teaches that bearing children out of wedlock is
1677 likely to have harmful consequences for the child, the child's
1678 parents and society;

1679 (g) Teaches young people how to reject sexual advances
1680 and how alcohol and drug use increase vulnerability to sexual
1681 advances; and
1682 (h) Teaches the importance of attaining
1683 self-sufficiency before engaging in sexual activity.
1684 (7) Beginning with the 2002-2003 school year and pursuant to
1685 appropriation therefor by the Legislature, in addition to other
1686 funds allotted under the Mississippi Adequate Education Program,
1687 each school district shall be provided funds from the Division of
1688 Medicaid school nurse waiver program authorized in Section
1689 43-13-117(47), Mississippi Code of 1972, for the purpose of
1690 employing qualified public school nurses in such school district
1691 using a school nurse to student attendance population ratio of
1692 1/750, which in no event shall be less than one (1) school nurse
1693 per school district, for such purpose. In the event the
1694 Legislature provides less funds than the total *** * *** funds needed
1695 for the public school nurse intervention program, those school
1696 districts with fewer school nurses shall be the first funded for
1697 such purpose, to the extent of funds available.
1698 (8) Prior to the 1998-1999 school year, nursing staff
1699 assigned to the program shall be employed through the local county
1700 health department and shall be subject to the supervision of the
1701 State Department of Health with input from local school officials.
1702 Local county health departments may contract with any
1703 comprehensive private primary health care facilities within their
1704 county to employ and utilize additional nursing staff. Beginning
1705 with the 1998-1999 school year, nursing staff assigned to the
1706 program shall be employed by the local school district and shall
1707 be designated as "health service coordinators," and shall be
1708 required to possess a registered nurse license (RN) as a minimum
1709 qualification.
1710 (9) Upon each student's enrollment, the parent or guardian
1711 shall be provided with information regarding the scope of the

1712 school nurse intervention program. The parent or guardian may
1713 provide the school administration with a written statement
1714 refusing all or any part of the nursing service. No child shall
1715 be required to undergo hearing and vision or scoliosis screening
1716 or any other physical examination or tests whose parent objects
1717 thereto on the grounds such screening, physical examination or
1718 tests are contrary to his sincerely held religious beliefs.
1719 (10) A consent form for reproductive health education shall
1720 be sent to the parent or guardian of each student upon his
1721 enrollment. If a response from the parent or guardian is not
1722 received within seven (7) days after the consent form is sent, the
1723 school shall send a letter to the student's home notifying the
1724 parent or guardian of the consent form. If the parent or guardian
1725 fails to respond to the letter within ten (10) days after it is
1726 sent, then the school principal shall be authorized to allow the
1727 student to receive reproductive health education. Reproductive
1728 health education shall include the teaching of total abstinence
1729 from premarital sex and, wherever practicable, reproductive health
1730 education should be taught in classes divided according to gender.
1731 All materials used in the reproductive health education program
1732 shall be placed in a convenient and easily accessible location for
1733 parental inspection. School nurses shall not dispense birth
1734 control pills or contraceptive devices in the school. Dispensing
1735 of such shall be the responsibility of the State Department of
1736 Health on a referral basis only.
1737 (11) No provision of this section shall be construed as
1738 prohibiting local school districts from accepting financial
1739 assistance of any type from the State of Mississippi or any other
1740 governmental entity, or any contribution, donation, gift, decree
1741 or bequest from any source which may be utilized for the
1742 maintenance or implementation of a school nurse intervention
1743 program in a public school system of this state.

1744 **SECTION 10.** Section 41-7-191, Mississippi Code of 1972, is
1745 amended as follows:
1746 41-7-191. (1) No person shall engage in any of the
1747 following activities without obtaining the required certificate of
1748 need:
1749 (a) The construction, development or other
1750 establishment of a new health care facility;
1751 (b) The relocation of a health care facility or portion
1752 thereof, or major medical equipment, unless such relocation of a
1753 health care facility or portion thereof, or major medical
1754 equipment, which does not involve a capital expenditure by or on
1755 behalf of a health care facility, is within five thousand two
1756 hundred eighty (5,280) feet from the main entrance of the health
1757 care facility;
1758 (c) A change over a period of two (2) years' time, as
1759 established by the State Department of Health, in existing bed
1760 complement through the addition of more than ten (10) beds or more
1761 than ten percent (10%) of the total bed capacity of a designated
1762 licensed category or subcategory of any health care facility,
1763 whichever is less, from one physical facility or site to another;
1764 the conversion over a period of two (2) years' time, as
1765 established by the State Department of Health, of existing bed
1766 complement of more than ten (10) beds or more than ten percent
1767 (10%) of the total bed capacity of a designated licensed category
1768 or subcategory of any such health care facility, whichever is
1769 less; or the alteration, modernizing or refurbishing of any unit
1770 or department wherein such beds may be located; provided, however,
1771 that from and after July 1, 1994, no health care facility shall be
1772 authorized to add any beds or convert any beds to another category
1773 of beds without a certificate of need under the authority of
1774 subsection (1)(c) of this section unless there is a projected need
1775 for such beds in the planning district in which the facility is
1776 located, as reported in the most current State Health Plan;

1777 (d) Offering of the following health services if those
1778 services have not been provided on a regular basis by the proposed
1779 provider of such services within the period of twelve (12) months
1780 prior to the time such services would be offered:
1781 (i) Open heart surgery services;
1782 (ii) Cardiac catheterization services;
1783 (iii) Comprehensive inpatient rehabilitation
1784 services;
1785 (iv) Licensed psychiatric services;
1786 (v) Licensed chemical dependency services;
1787 (vi) Radiation therapy services;
1788 (vii) Diagnostic imaging services of an invasive
1789 nature, i.e. invasive digital angiography;
1790 (viii) Nursing home care as defined in
1791 subparagraphs (iv), (vi) and (viii) of Section 41-7-173(h);
1792 (ix) Home health services;
1793 (x) Swing-bed services;
1794 (xi) Ambulatory surgical services;
1795 (xii) Magnetic resonance imaging services;
1796 (xiii) Extracorporeal shock wave lithotripsy
1797 services;
1798 (xiv) Long-term care hospital services;
1799 (xv) Positron Emission Tomography (PET) services;
1800 (e) The relocation of one or more health services from
1801 one physical facility or site to another physical facility or
1802 site, unless such relocation, which does not involve a capital
1803 expenditure by or on behalf of a health care facility, (i) is to a
1804 physical facility or site within one thousand three hundred twenty
1805 (1,320) feet from the main entrance of the health care facility
1806 where the health care service is located, or (ii) is the result of
1807 an order of a court of appropriate jurisdiction or a result of
1808 pending litigation in such court, or by order of the State
1809 Department of Health, or by order of any other agency or legal

1810 entity of the state, the federal government, or any political
1811 subdivision of either, whose order is also approved by the State
1812 Department of Health;
1813 (f) The acquisition or otherwise control of any major
1814 medical equipment for the provision of medical services; provided,
1815 however, (i) the acquisition of any major medical equipment used
1816 only for research purposes, and (ii) the acquisition of major
1817 medical equipment to replace medical equipment for which a
1818 facility is already providing medical services and for which the
1819 State Department of Health has been notified before the date of
1820 such acquisition shall be exempt from this paragraph; an
1821 acquisition for less than fair market value must be reviewed, if
1822 the acquisition at fair market value would be subject to review;
1823 (g) Changes of ownership of existing health care
1824 facilities in which a notice of intent is not filed with the State
1825 Department of Health at least thirty (30) days prior to the date
1826 such change of ownership occurs, or a change in services or bed
1827 capacity as prescribed in paragraph (c) or (d) of this subsection
1828 as a result of the change of ownership; an acquisition for less
1829 than fair market value must be reviewed, if the acquisition at
1830 fair market value would be subject to review;
1831 (h) The change of ownership of any health care facility
1832 defined in subparagraphs (iv), (vi) and (viii) of Section
1833 41-7-173(h), in which a notice of intent as described in paragraph
1834 (g) has not been filed and if the Executive Director, Division of
1835 Medicaid, Office of the Governor, has not certified in writing
1836 that there will be no increase in allowable costs to Medicaid from
1837 revaluation of the assets or from increased interest and
1838 depreciation as a result of the proposed change of ownership;
1839 (i) Any activity described in paragraphs (a) through
1840 (h) if undertaken by any person if that same activity would
1841 require certificate of need approval if undertaken by a health
1842 care facility;

1843 (j) Any capital expenditure or deferred capital
1844 expenditure by or on behalf of a health care facility not covered
1845 by paragraphs (a) through (h);
1846 (k) The contracting of a health care facility as
1847 defined in subparagraphs (i) through (viii) of Section 41-7-173(h)
1848 to establish a home office, subunit, or branch office in the space
1849 operated as a health care facility through a formal arrangement
1850 with an existing health care facility as defined in subparagraph
1851 (ix) of Section 41-7-173(h).
1852 (2) The State Department of Health shall not grant approval
1853 for or issue a certificate of need to any person proposing the new
1854 construction of, addition to, or expansion of any health care
1855 facility defined in subparagraphs (iv) (skilled nursing facility)
1856 and (vi) (intermediate care facility) of Section 41-7-173(h) or
1857 the conversion of vacant hospital beds to provide skilled or
1858 intermediate nursing home care, except as hereinafter authorized:
1859 (a) The department may issue a certificate of need to
1860 any person proposing the new construction of any health care
1861 facility defined in subparagraphs (iv) and (vi) of Section
1862 41-7-173(h) as part of a life care retirement facility, in any
1863 county bordering on the Gulf of Mexico in which is located a
1864 National Aeronautics and Space Administration facility, not to
1865 exceed forty (40) beds. From and after July 1, 1999, there shall
1866 be no prohibition or restrictions on participation in the Medicaid
1867 program (Section 43-13-101 et seq.) for the beds in the health
1868 care facility that were authorized under this paragraph (a).
1869 (b) The department may issue certificates of need in
1870 Harrison County to provide skilled nursing home care for
1871 Alzheimer's Disease patients and other patients, not to exceed one
1872 hundred fifty (150) beds. From and after July 1, 1999, there
1873 shall be no prohibition or restrictions on participation in the
1874 Medicaid program (Section 43-13-101 et seq.) for the beds in the
1875 nursing facilities that were authorized under this paragraph (b).

1876 (c) The department may issue a certificate of need for
1877 the addition to or expansion of any skilled nursing facility that
1878 is part of an existing continuing care retirement community
1879 located in Madison County, provided that the recipient of the
1880 certificate of need agrees in writing that the skilled nursing
1881 facility will not at any time participate in the Medicaid program
1882 (Section 43-13-101 et seq.) or admit or keep any patients in the
1883 skilled nursing facility who are participating in the Medicaid
1884 program. This written agreement by the recipient of the
1885 certificate of need shall be fully binding on any subsequent owner
1886 of the skilled nursing facility, if the ownership of the facility
1887 is transferred at any time after the issuance of the certificate
1888 of need. Agreement that the skilled nursing facility will not
1889 participate in the Medicaid program shall be a condition of the
1890 issuance of a certificate of need to any person under this
1891 paragraph (c), and if such skilled nursing facility at any time
1892 after the issuance of the certificate of need, regardless of the
1893 ownership of the facility, participates in the Medicaid program or
1894 admits or keeps any patients in the facility who are participating
1895 in the Medicaid program, the State Department of Health shall
1896 revoke the certificate of need, if it is still outstanding, and
1897 shall deny or revoke the license of the skilled nursing facility,
1898 at the time that the department determines, after a hearing
1899 complying with due process, that the facility has failed to comply
1900 with any of the conditions upon which the certificate of need was
1901 issued, as provided in this paragraph and in the written agreement
1902 by the recipient of the certificate of need. The total number of
1903 beds that may be authorized under the authority of this paragraph
1904 (c) shall not exceed sixty (60) beds.
1905 (d) The State Department of Health may issue a
1906 certificate of need to any hospital located in DeSoto County for
1907 the new construction of a skilled nursing facility, not to exceed
1908 one hundred twenty (120) beds, in DeSoto County. From and after

1909 July 1, 1999, there shall be no prohibition or restrictions on
1910 participation in the Medicaid program (Section 43-13-101 et seq.)
1911 for the beds in the nursing facility that were authorized under
1912 this paragraph (d).

1913 (e) The State Department of Health may issue a
1914 certificate of need for the construction of a nursing facility or
1915 the conversion of beds to nursing facility beds at a personal care
1916 facility for the elderly in Lowndes County that is owned and
1917 operated by a Mississippi nonprofit corporation, not to exceed
1918 sixty (60) beds. From and after July 1, 1999, there shall be no
1919 prohibition or restrictions on participation in the Medicaid
1920 program (Section 43-13-101 et seq.) for the beds in the nursing
1921 facility that were authorized under this paragraph (e).

1922 (f) The State Department of Health may issue a
1923 certificate of need for conversion of a county hospital facility
1924 in Itawamba County to a nursing facility, not to exceed sixty (60)
1925 beds, including any necessary construction, renovation or
1926 expansion. From and after July 1, 1999, there shall be no
1927 prohibition or restrictions on participation in the Medicaid
1928 program (Section 43-13-101 et seq.) for the beds in the nursing
1929 facility that were authorized under this paragraph (f).

1930 (g) The State Department of Health may issue a
1931 certificate of need for the construction or expansion of nursing
1932 facility beds or the conversion of other beds to nursing facility
1933 beds in either Hinds, Madison or Rankin Counties, not to exceed
1934 sixty (60) beds. From and after July 1, 1999, there shall be no
1935 prohibition or restrictions on participation in the Medicaid
1936 program (Section 43-13-101 et seq.) for the beds in the nursing
1937 facility that were authorized under this paragraph (g).

1938 (h) The State Department of Health may issue a
1939 certificate of need for the construction or expansion of nursing
1940 facility beds or the conversion of other beds to nursing facility
1941 beds in either Hancock, Harrison or Jackson Counties, not to

1942 exceed sixty (60) beds. From and after July 1, 1999, there shall
1943 be no prohibition or restrictions on participation in the Medicaid
1944 program (Section 43-13-101 et seq.) for the beds in the facility
1945 that were authorized under this paragraph (h).
1946 (i) The department may issue a certificate of need for
1947 the new construction of a skilled nursing facility in Leake
1948 County, provided that the recipient of the certificate of need
1949 agrees in writing that the skilled nursing facility will not at
1950 any time participate in the Medicaid program (Section 43-13-101 et
1951 seq.) or admit or keep any patients in the skilled nursing
1952 facility who are participating in the Medicaid program. This
1953 written agreement by the recipient of the certificate of need
1954 shall be fully binding on any subsequent owner of the skilled
1955 nursing facility, if the ownership of the facility is transferred
1956 at any time after the issuance of the certificate of need.
1957 Agreement that the skilled nursing facility will not participate
1958 in the Medicaid program shall be a condition of the issuance of a
1959 certificate of need to any person under this paragraph (i), and if
1960 such skilled nursing facility at any time after the issuance of
1961 the certificate of need, regardless of the ownership of the
1962 facility, participates in the Medicaid program or admits or keeps
1963 any patients in the facility who are participating in the Medicaid
1964 program, the State Department of Health shall revoke the
1965 certificate of need, if it is still outstanding, and shall deny or
1966 revoke the license of the skilled nursing facility, at the time
1967 that the department determines, after a hearing complying with due
1968 process, that the facility has failed to comply with any of the
1969 conditions upon which the certificate of need was issued, as
1970 provided in this paragraph and in the written agreement by the
1971 recipient of the certificate of need. The provision of Section
1972 43-7-193(1) regarding substantial compliance of the projection of
1973 need as reported in the current State Health Plan is waived for
1974 the purposes of this paragraph. The total number of nursing

1975 facility beds that may be authorized by any certificate of need
1976 issued under this paragraph (i) shall not exceed sixty (60) beds.
1977 If the skilled nursing facility authorized by the certificate of
1978 need issued under this paragraph is not constructed and fully
1979 operational within eighteen (18) months after July 1, 1994, the
1980 State Department of Health, after a hearing complying with due
1981 process, shall revoke the certificate of need, if it is still
1982 outstanding, and shall not issue a license for the skilled nursing
1983 facility at any time after the expiration of the eighteen-month
1984 period.

1985 (j) The department may issue certificates of need to
1986 allow any existing freestanding long-term care facility in
1987 Tishomingo County and Hancock County that on July 1, 1995, is
1988 licensed with fewer than sixty (60) beds. For the purposes of
1989 this paragraph (j), the provision of Section 41-7-193(1) requiring
1990 substantial compliance with the projection of need as reported in
1991 the current State Health Plan is waived. From and after July 1,
1992 1999, there shall be no prohibition or restrictions on
1993 participation in the Medicaid program (Section 43-13-101 et seq.)
1994 for the beds in the long-term care facilities that were authorized
1995 under this paragraph (j).

1996 (k) The department may issue a certificate of need for
1997 the construction of a nursing facility at a continuing care
1998 retirement community in Lowndes County. The total number of beds
1999 that may be authorized under the authority of this paragraph (k)
2000 shall not exceed sixty (60) beds. From and after July 1, 2001,
2001 the prohibition on the facility participating in the Medicaid
2002 program (Section 43-13-101 et seq.) that was a condition of
2003 issuance of the certificate of need under this paragraph (k) shall
2004 be revised as follows: The nursing facility may participate in
2005 the Medicaid program from and after July 1, 2001, if the owner of
2006 the facility on July 1, 2001, agrees in writing that no more than
2007 thirty (30) of the beds at the facility will be certified for

2008 participation in the Medicaid program, and that no claim will be
2009 submitted for Medicaid reimbursement for more than thirty (30)
2010 patients in the facility in any month or for any patient in the
2011 facility who is in a bed that is not Medicaid-certified. This
2012 written agreement by the owner of the facility shall be a
2013 condition of licensure of the facility, and the agreement shall be
2014 fully binding on any subsequent owner of the facility if the
2015 ownership of the facility is transferred at any time after July 1,
2016 2001. After this written agreement is executed, the Division of
2017 Medicaid and the State Department of Health shall not certify more
2018 than thirty (30) of the beds in the facility for participation in
2019 the Medicaid program. If the facility violates the terms of the
2020 written agreement by admitting or keeping in the facility on a
2021 regular or continuing basis more than thirty (30) patients who are
2022 participating in the Medicaid program, the State Department of
2023 Health shall revoke the license of the facility, at the time that
2024 the department determines, after a hearing complying with due
2025 process, that the facility has violated the written agreement.
2026 (l) Provided that funds are specifically appropriated
2027 therefor by the Legislature, the department may issue a
2028 certificate of need to a rehabilitation hospital in Hinds County
2029 for the construction of a sixty-bed long-term care nursing
2030 facility dedicated to the care and treatment of persons with
2031 severe disabilities including persons with spinal cord and
2032 closed-head injuries and ventilator-dependent patients. The
2033 provision of Section 41-7-193(1) regarding substantial compliance
2034 with projection of need as reported in the current State Health
2035 Plan is hereby waived for the purpose of this paragraph.
2036 (m) The State Department of Health may issue a
2037 certificate of need to a county-owned hospital in the Second
2038 Judicial District of Panola County for the conversion of not more
2039 than seventy-two (72) hospital beds to nursing facility beds,
2040 provided that the recipient of the certificate of need agrees in

2041 writing that none of the beds at the nursing facility will be
2042 certified for participation in the Medicaid program (Section
2043 43-13-101 et seq.), and that no claim will be submitted for
2044 Medicaid reimbursement in the nursing facility in any day or for
2045 any patient in the nursing facility. This written agreement by
2046 the recipient of the certificate of need shall be a condition of
2047 the issuance of the certificate of need under this paragraph, and
2048 the agreement shall be fully binding on any subsequent owner of
2049 the nursing facility if the ownership of the nursing facility is
2050 transferred at any time after the issuance of the certificate of
2051 need. After this written agreement is executed, the Division of
2052 Medicaid and the State Department of Health shall not certify any
2053 of the beds in the nursing facility for participation in the
2054 Medicaid program. If the nursing facility violates the terms of
2055 the written agreement by admitting or keeping in the nursing
2056 facility on a regular or continuing basis any patients who are
2057 participating in the Medicaid program, the State Department of
2058 Health shall revoke the license of the nursing facility, at the
2059 time that the department determines, after a hearing complying
2060 with due process, that the nursing facility has violated the
2061 condition upon which the certificate of need was issued, as
2062 provided in this paragraph and in the written agreement. If the
2063 certificate of need authorized under this paragraph is not issued
2064 within twelve (12) months after July 1, 2001, the department shall
2065 deny the application for the certificate of need and shall not
2066 issue the certificate of need at any time after the twelve-month
2067 period, unless the issuance is contested. If the certificate of
2068 need is issued and substantial construction of the nursing
2069 facility beds has not commenced within eighteen (18) months after
2070 July 1, 2001, the State Department of Health, after a hearing
2071 complying with due process, shall revoke the certificate of need
2072 if it is still outstanding, and the department shall not issue a
2073 license for the nursing facility at any time after the

2074 eighteen-month period. Provided, however, that if the issuance of
2075 the certificate of need is contested, the department shall require
2076 substantial construction of the nursing facility beds within six
2077 (6) months after final adjudication on the issuance of the
2078 certificate of need.

2079 (n) The department may issue a certificate of need for
2080 the new construction, addition or conversion of skilled nursing
2081 facility beds in Madison County, provided that the recipient of
2082 the certificate of need agrees in writing that the skilled nursing
2083 facility will not at any time participate in the Medicaid program
2084 (Section 43-13-101 et seq.) or admit or keep any patients in the
2085 skilled nursing facility who are participating in the Medicaid
2086 program. This written agreement by the recipient of the
2087 certificate of need shall be fully binding on any subsequent owner
2088 of the skilled nursing facility, if the ownership of the facility
2089 is transferred at any time after the issuance of the certificate
2090 of need. Agreement that the skilled nursing facility will not
2091 participate in the Medicaid program shall be a condition of the
2092 issuance of a certificate of need to any person under this
2093 paragraph (n), and if such skilled nursing facility at any time
2094 after the issuance of the certificate of need, regardless of the
2095 ownership of the facility, participates in the Medicaid program or
2096 admits or keeps any patients in the facility who are participating
2097 in the Medicaid program, the State Department of Health shall
2098 revoke the certificate of need, if it is still outstanding, and
2099 shall deny or revoke the license of the skilled nursing facility,
2100 at the time that the department determines, after a hearing
2101 complying with due process, that the facility has failed to comply
2102 with any of the conditions upon which the certificate of need was
2103 issued, as provided in this paragraph and in the written agreement
2104 by the recipient of the certificate of need. The total number of
2105 nursing facility beds that may be authorized by any certificate of
2106 need issued under this paragraph (n) shall not exceed sixty (60)

2107 beds. If the certificate of need authorized under this paragraph
2108 is not issued within twelve (12) months after July 1, 1998, the
2109 department shall deny the application for the certificate of need
2110 and shall not issue the certificate of need at any time after the
2111 twelve-month period, unless the issuance is contested. If the
2112 certificate of need is issued and substantial construction of the
2113 nursing facility beds has not commenced within eighteen (18)
2114 months after the effective date of July 1, 1998, the State
2115 Department of Health, after a hearing complying with due process,
2116 shall revoke the certificate of need if it is still outstanding,
2117 and the department shall not issue a license for the nursing
2118 facility at any time after the eighteen-month period. Provided,
2119 however, that if the issuance of the certificate of need is
2120 contested, the department shall require substantial construction
2121 of the nursing facility beds within six (6) months after final
2122 adjudication on the issuance of the certificate of need.

2123 (o) The department may issue a certificate of need for
2124 the new construction, addition or conversion of skilled nursing
2125 facility beds in Leake County, provided that the recipient of the
2126 certificate of need agrees in writing that the skilled nursing
2127 facility will not at any time participate in the Medicaid program
2128 (Section 43-13-101 et seq.) or admit or keep any patients in the
2129 skilled nursing facility who are participating in the Medicaid
2130 program. This written agreement by the recipient of the
2131 certificate of need shall be fully binding on any subsequent owner
2132 of the skilled nursing facility, if the ownership of the facility
2133 is transferred at any time after the issuance of the certificate
2134 of need. Agreement that the skilled nursing facility will not
2135 participate in the Medicaid program shall be a condition of the
2136 issuance of a certificate of need to any person under this
2137 paragraph (o), and if such skilled nursing facility at any time
2138 after the issuance of the certificate of need, regardless of the
2139 ownership of the facility, participates in the Medicaid program or

2140 admits or keeps any patients in the facility who are participating
2141 in the Medicaid program, the State Department of Health shall
2142 revoke the certificate of need, if it is still outstanding, and
2143 shall deny or revoke the license of the skilled nursing facility,
2144 at the time that the department determines, after a hearing
2145 complying with due process, that the facility has failed to comply
2146 with any of the conditions upon which the certificate of need was
2147 issued, as provided in this paragraph and in the written agreement
2148 by the recipient of the certificate of need. The total number of
2149 nursing facility beds that may be authorized by any certificate of
2150 need issued under this paragraph (o) shall not exceed sixty (60)
2151 beds. If the certificate of need authorized under this paragraph
2152 is not issued within twelve (12) months after July 1, 2001, the
2153 department shall deny the application for the certificate of need
2154 and shall not issue the certificate of need at any time after the
2155 twelve-month period, unless the issuance is contested. If the
2156 certificate of need is issued and substantial construction of the
2157 nursing facility beds has not commenced within eighteen (18)
2158 months after the effective date of July 1, 2001, the State
2159 Department of Health, after a hearing complying with due process,
2160 shall revoke the certificate of need if it is still outstanding,
2161 and the department shall not issue a license for the nursing
2162 facility at any time after the eighteen-month period. Provided,
2163 however, that if the issuance of the certificate of need is
2164 contested, the department shall require substantial construction
2165 of the nursing facility beds within six (6) months after final
2166 adjudication on the issuance of the certificate of need.
2167 (p) The department may issue a certificate of need for
2168 the construction of a municipally-owned nursing facility within
2169 the Town of Belmont in Tishomingo County, not to exceed sixty (60)
2170 beds, provided that the recipient of the certificate of need
2171 agrees in writing that the skilled nursing facility will not at
2172 any time participate in the Medicaid program (Section 43-13-101 et

2173 seq.) or admit or keep any patients in the skilled nursing
2174 facility who are participating in the Medicaid program. This
2175 written agreement by the recipient of the certificate of need
2176 shall be fully binding on any subsequent owner of the skilled
2177 nursing facility, if the ownership of the facility is transferred
2178 at any time after the issuance of the certificate of need.
2179 Agreement that the skilled nursing facility will not participate
2180 in the Medicaid program shall be a condition of the issuance of a
2181 certificate of need to any person under this paragraph (p), and if
2182 such skilled nursing facility at any time after the issuance of
2183 the certificate of need, regardless of the ownership of the
2184 facility, participates in the Medicaid program or admits or keeps
2185 any patients in the facility who are participating in the Medicaid
2186 program, the State Department of Health shall revoke the
2187 certificate of need, if it is still outstanding, and shall deny or
2188 revoke the license of the skilled nursing facility, at the time
2189 that the department determines, after a hearing complying with due
2190 process, that the facility has failed to comply with any of the
2191 conditions upon which the certificate of need was issued, as
2192 provided in this paragraph and in the written agreement by the
2193 recipient of the certificate of need. The provision of Section
2194 43-7-193(1) regarding substantial compliance of the projection of
2195 need as reported in the current State Health Plan is waived for
2196 the purposes of this paragraph. If the certificate of need
2197 authorized under this paragraph is not issued within twelve (12)
2198 months after July 1, 1998, the department shall deny the
2199 application for the certificate of need and shall not issue the
2200 certificate of need at any time after the twelve-month period,
2201 unless the issuance is contested. If the certificate of need is
2202 issued and substantial construction of the nursing facility beds
2203 has not commenced within eighteen (18) months after July 1, 1998,
2204 the State Department of Health, after a hearing complying with due
2205 process, shall revoke the certificate of need if it is still

2206 outstanding, and the department shall not issue a license for the
2207 nursing facility at any time after the eighteen-month period.
2208 Provided, however, that if the issuance of the certificate of need
2209 is contested, the department shall require substantial
2210 construction of the nursing facility beds within six (6) months
2211 after final adjudication on the issuance of the certificate of
2212 need.

2213 (q) (i) Beginning on July 1, 1999, the State
2214 Department of Health shall issue certificates of need during each
2215 of the next four (4) fiscal years for the construction or
2216 expansion of nursing facility beds or the conversion of other beds
2217 to nursing facility beds in each county in the state having a need
2218 for fifty (50) or more additional nursing facility beds, as shown
2219 in the fiscal year 1999 State Health Plan, in the manner provided
2220 in this paragraph (q). The total number of nursing facility beds
2221 that may be authorized by any certificate of need authorized under
2222 this paragraph (q) shall not exceed sixty (60) beds.

2223 (ii) Subject to the provisions of subparagraph
2224 (v), during each of the next four (4) fiscal years, the department
2225 shall issue six (6) certificates of need for new nursing facility
2226 beds, as follows: During fiscal years 2000, 2001 and 2002, one
2227 (1) certificate of need shall be issued for new nursing facility
2228 beds in the county in each of the four (4) Long-Term Care Planning
2229 Districts designated in the fiscal year 1999 State Health Plan
2230 that has the highest need in the district for those beds; and two
2231 (2) certificates of need shall be issued for new nursing facility
2232 beds in the two (2) counties from the state at large that have the
2233 highest need in the state for those beds, when considering the
2234 need on a statewide basis and without regard to the Long-Term Care
2235 Planning Districts in which the counties are located. During
2236 fiscal year 2003, one (1) certificate of need shall be issued for
2237 new nursing facility beds in any county having a need for fifty
2238 (50) or more additional nursing facility beds, as shown in the

2239 fiscal year 1999 State Health Plan, that has not received a
2240 certificate of need under this paragraph (q) during the three (3)
2241 previous fiscal years. During fiscal year 2000, in addition to
2242 the six (6) certificates of need authorized in this subparagraph,
2243 the department also shall issue a certificate of need for new
2244 nursing facility beds in Amite County and a certificate of need
2245 for new nursing facility beds in Carroll County.

2246 (iii) Subject to the provisions of subparagraph
2247 (v), the certificate of need issued under subparagraph (ii) for
2248 nursing facility beds in each Long-Term Care Planning District
2249 during each fiscal year shall first be available for nursing
2250 facility beds in the county in the district having the highest
2251 need for those beds, as shown in the fiscal year 1999 State Health
2252 Plan. If there are no applications for a certificate of need for
2253 nursing facility beds in the county having the highest need for
2254 those beds by the date specified by the department, then the
2255 certificate of need shall be available for nursing facility beds
2256 in other counties in the district in descending order of the need
2257 for those beds, from the county with the second highest need to
2258 the county with the lowest need, until an application is received
2259 for nursing facility beds in an eligible county in the district.

2260 (iv) Subject to the provisions of subparagraph
2261 (v), the certificate of need issued under subparagraph (ii) for
2262 nursing facility beds in the two (2) counties from the state at
2263 large during each fiscal year shall first be available for nursing
2264 facility beds in the two (2) counties that have the highest need
2265 in the state for those beds, as shown in the fiscal year 1999
2266 State Health Plan, when considering the need on a statewide basis
2267 and without regard to the Long-Term Care Planning Districts in
2268 which the counties are located. If there are no applications for
2269 a certificate of need for nursing facility beds in either of the
2270 two (2) counties having the highest need for those beds on a
2271 statewide basis by the date specified by the department, then the

2272 certificate of need shall be available for nursing facility beds
2273 in other counties from the state at large in descending order of
2274 the need for those beds on a statewide basis, from the county with
2275 the second highest need to the county with the lowest need, until
2276 an application is received for nursing facility beds in an
2277 eligible county from the state at large.

2278 (v) If a certificate of need is authorized to be
2279 issued under this paragraph (q) for nursing facility beds in a
2280 county on the basis of the need in the Long-Term Care Planning
2281 District during any fiscal year of the four-year period, a
2282 certificate of need shall not also be available under this
2283 paragraph (q) for additional nursing facility beds in that county
2284 on the basis of the need in the state at large, and that county
2285 shall be excluded in determining which counties have the highest
2286 need for nursing facility beds in the state at large for that
2287 fiscal year. After a certificate of need has been issued under
2288 this paragraph (q) for nursing facility beds in a county during
2289 any fiscal year of the four-year period, a certificate of need
2290 shall not be available again under this paragraph (q) for
2291 additional nursing facility beds in that county during the
2292 four-year period, and that county shall be excluded in determining
2293 which counties have the highest need for nursing facility beds in
2294 succeeding fiscal years.

2295 (vi) If more than one (1) application is made for
2296 a certificate of need for nursing home facility beds available
2297 under this paragraph (q), in Yalobusha, Newton or Tallahatchie
2298 County, and one (1) of the applicants is a county-owned hospital
2299 located in the county where the nursing facility beds are
2300 available, the department shall give priority to the county-owned
2301 hospital in granting the certificate of need if the following
2302 conditions are met:

2303 1. The county-owned hospital fully meets all
2304 applicable criteria and standards required to obtain a certificate
2305 of need for the nursing facility beds; and
2306 2. The county-owned hospital's qualifications
2307 for the certificate of need, as shown in its application and as
2308 determined by the department, are at least equal to the
2309 qualifications of the other applicants for the certificate of
2310 need.
2311 (r) (i) Beginning on July 1, 1999, the State
2312 Department of Health shall issue certificates of need during each
2313 of the next two (2) fiscal years for the construction or expansion
2314 of nursing facility beds or the conversion of other beds to
2315 nursing facility beds in each of the four (4) Long-Term Care
2316 Planning Districts designated in the fiscal year 1999 State Health
2317 Plan, to provide care exclusively to patients with Alzheimer's
2318 disease.
2319 (ii) Not more than twenty (20) beds may be
2320 authorized by any certificate of need issued under this paragraph
2321 (r), and not more than a total of sixty (60) beds may be
2322 authorized in any Long-Term Care Planning District by all
2323 certificates of need issued under this paragraph (r). However,
2324 the total number of beds that may be authorized by all
2325 certificates of need issued under this paragraph (r) during any
2326 fiscal year shall not exceed one hundred twenty (120) beds, and
2327 the total number of beds that may be authorized in any Long-Term
2328 Care Planning District during any fiscal year shall not exceed
2329 forty (40) beds. Of the certificates of need that are issued for
2330 each Long-Term Care Planning District during the next two (2)
2331 fiscal years, at least one (1) shall be issued for beds in the
2332 northern part of the district, at least one (1) shall be issued
2333 for beds in the central part of the district, and at least one (1)
2334 shall be issued for beds in the southern part of the district.

2335 (iii) The State Department of Health, in
2336 consultation with the Department of Mental Health and the Division
2337 of Medicaid, shall develop and prescribe the staffing levels,
2338 space requirements and other standards and requirements that must
2339 be met with regard to the nursing facility beds authorized under
2340 this paragraph (r) to provide care exclusively to patients with
2341 Alzheimer's disease.
2342 (3) The State Department of Health may grant approval for
2343 and issue certificates of need to any person proposing the new
2344 construction of, addition to, conversion of beds of or expansion
2345 of any health care facility defined in subparagraph (x)
2346 (psychiatric residential treatment facility) of Section
2347 41-7-173(h). The total number of beds which may be authorized by
2348 such certificates of need shall not exceed three hundred
2349 thirty-four (334) beds for the entire state.
2350 (a) Of the total number of beds authorized under this
2351 subsection, the department shall issue a certificate of need to a
2352 privately owned psychiatric residential treatment facility in
2353 Simpson County for the conversion of sixteen (16) intermediate
2354 care facility for the mentally retarded (ICF-MR) beds to
2355 psychiatric residential treatment facility beds, provided that
2356 facility agrees in writing that the facility shall give priority
2357 for the use of those sixteen (16) beds to Mississippi residents
2358 who are presently being treated in out-of-state facilities.
2359 (b) Of the total number of beds authorized under this
2360 subsection, the department may issue a certificate or certificates
2361 of need for the construction or expansion of psychiatric
2362 residential treatment facility beds or the conversion of other
2363 beds to psychiatric residential treatment facility beds in Warren
2364 County, not to exceed sixty (60) psychiatric residential treatment
2365 facility beds, provided that the facility agrees in writing that
2366 no more than thirty (30) of the beds at the psychiatric
2367 residential treatment facility will be certified for participation

2368 in the Medicaid program (Section 43-13-101 et seq.) for the use of
2369 any patients other than those who are participating only in the
2370 Medicaid program of another state, and that no claim will be
2371 submitted to the Division of Medicaid for Medicaid reimbursement
2372 for more than thirty (30) patients in the psychiatric residential
2373 treatment facility in any day or for any patient in the
2374 psychiatric residential treatment facility who is in a bed that is
2375 not Medicaid-certified. This written agreement by the recipient
2376 of the certificate of need shall be a condition of the issuance of
2377 the certificate of need under this paragraph, and the agreement
2378 shall be fully binding on any subsequent owner of the psychiatric
2379 residential treatment facility if the ownership of the facility is
2380 transferred at any time after the issuance of the certificate of
2381 need. After this written agreement is executed, the Division of
2382 Medicaid and the State Department of Health shall not certify more
2383 than thirty (30) of the beds in the psychiatric residential
2384 treatment facility for participation in the Medicaid program for
2385 the use of any patients other than those who are participating
2386 only in the Medicaid program of another state. If the psychiatric
2387 residential treatment facility violates the terms of the written
2388 agreement by admitting or keeping in the facility on a regular or
2389 continuing basis more than thirty (30) patients who are
2390 participating in the Mississippi Medicaid program, the State
2391 Department of Health shall revoke the license of the facility, at
2392 the time that the department determines, after a hearing complying
2393 with due process, that the facility has violated the condition
2394 upon which the certificate of need was issued, as provided in this
2395 paragraph and in the written agreement.
2396 If by January 1, 2002, there has been no significant
2397 commencement of construction of the beds authorized under this
2398 paragraph (b), or no significant action taken to convert existing
2399 beds to the beds authorized under this paragraph, then the
2400 certificate of need that was previously issued under this

2401 paragraph shall expire. If the previously issued certificate of
2402 need expires, the department may accept applications for issuance
2403 of another certificate of need for the beds authorized under this
2404 paragraph, and may issue a certificate of need to authorize the
2405 construction, expansion or conversion of the beds authorized under
2406 this paragraph.

2407 (c) Of the total number of beds authorized under this
2408 subsection, the department shall issue a certificate of need to a
2409 hospital currently operating Medicaid-certified acute psychiatric
2410 beds for adolescents in DeSoto County, for the establishment of a
2411 forty-bed psychiatric residential treatment facility in DeSoto
2412 County, provided that the hospital agrees in writing (i) that the
2413 hospital shall give priority for the use of those forty (40) beds
2414 to Mississippi residents who are presently being treated in
2415 out-of-state facilities, and (ii) that no more than fifteen (15)
2416 of the beds at the psychiatric residential treatment facility will
2417 be certified for participation in the Medicaid program (Section
2418 43-13-101 et seq.), and that no claim will be submitted for
2419 Medicaid reimbursement for more than fifteen (15) patients in the
2420 psychiatric residential treatment facility in any day or for any
2421 patient in the psychiatric residential treatment facility who is
2422 in a bed that is not Medicaid-certified. This written agreement
2423 by the recipient of the certificate of need shall be a condition
2424 of the issuance of the certificate of need under this paragraph,
2425 and the agreement shall be fully binding on any subsequent owner
2426 of the psychiatric residential treatment facility if the ownership
2427 of the facility is transferred at any time after the issuance of
2428 the certificate of need. After this written agreement is
2429 executed, the Division of Medicaid and the State Department of
2430 Health shall not certify more than fifteen (15) of the beds in the
2431 psychiatric residential treatment facility for participation in
2432 the Medicaid program. If the psychiatric residential treatment
2433 facility violates the terms of the written agreement by admitting

2434 or keeping in the facility on a regular or continuing basis more
2435 than fifteen (15) patients who are participating in the Medicaid
2436 program, the State Department of Health shall revoke the license
2437 of the facility, at the time that the department determines, after
2438 a hearing complying with due process, that the facility has
2439 violated the condition upon which the certificate of need was
2440 issued, as provided in this paragraph and in the written
2441 agreement.

2442 (d) Of the total number of beds authorized under this
2443 subsection, the department may issue a certificate or certificates
2444 of need for the construction or expansion of psychiatric
2445 residential treatment facility beds or the conversion of other
2446 beds to psychiatric treatment facility beds, not to exceed thirty
2447 (30) psychiatric residential treatment facility beds, in either
2448 Alcorn, Tishomingo, Prentiss, Lee, Itawamba, Monroe, Chickasaw,
2449 Pontotoc, Calhoun, Lafayette, Union, Benton or Tippah Counties.

2450 (e) Of the total number of beds authorized under this
2451 subsection (3) the department shall issue a certificate of need to
2452 a privately owned, nonprofit psychiatric residential treatment
2453 facility in Hinds County for an eight-bed expansion of the
2454 facility, provided that the facility agrees in writing that the
2455 facility shall give priority for the use of those eight (8) beds
2456 to Mississippi residents who are presently being treated in
2457 out-of-state facilities.

2458 (f) The department shall issue a certificate of need to
2459 a one-hundred-thirty-four-bed specialty hospital located on
2460 twenty-nine and forty-four one-hundredths (29.44) commercial acres
2461 at 5900 Highway 39 North in Meridian (Lauderdale County),
2462 Mississippi, for the addition, construction or expansion of
2463 child/adolescent psychiatric residential treatment facility beds
2464 in Lauderdale County. As a condition of issuance of the
2465 certificate of need under this paragraph, the facility shall give
2466 priority in admissions to the child/adolescent psychiatric

2467 residential treatment facility beds authorized under this
2468 paragraph to patients who otherwise would require out-of-state
2469 placement. The Division of Medicaid, in conjunction with the
2470 Department of Human Services, shall furnish the facility a list of
2471 all out-of-state patients on a quarterly basis. Furthermore,
2472 notice shall also be provided to the parent, custodial parent or
2473 guardian of each out-of-state patient notifying them of the
2474 priority status granted by this paragraph. For purposes of this
2475 paragraph, the provisions of Section 41-7-193(1) requiring
2476 substantial compliance with the projection of need as reported in
2477 the current State Health Plan are waived. The total number of
2478 child/adolescent psychiatric residential treatment facility beds
2479 that may be authorized under the authority of this paragraph shall
2480 be sixty (60) beds. There shall be no prohibition or restrictions
2481 on participation in the Medicaid program (Section 43-13-101 et
2482 seq.) for the person receiving the certificate of need authorized
2483 under this paragraph or for the beds converted pursuant to the
2484 authority of that certificate of need.
2485 (4) (a) From and after July 1, 1993, the department shall
2486 not issue a certificate of need to any person for the new
2487 construction of any hospital, psychiatric hospital or chemical
2488 dependency hospital that will contain any child/adolescent
2489 psychiatric or child/adolescent chemical dependency beds, or for
2490 the conversion of any other health care facility to a hospital,
2491 psychiatric hospital or chemical dependency hospital that will
2492 contain any child/adolescent psychiatric or child/adolescent
2493 chemical dependency beds, or for the addition of any
2494 child/adolescent psychiatric or child/adolescent chemical
2495 dependency beds in any hospital, psychiatric hospital or chemical
2496 dependency hospital, or for the conversion of any beds of another
2497 category in any hospital, psychiatric hospital or chemical
2498 dependency hospital to child/adolescent psychiatric or

2499 child/adolescent chemical dependency beds, except as hereinafter
2500 authorized:

2501 (i) The department may issue certificates of need
2502 to any person for any purpose described in this subsection,
2503 provided that the hospital, psychiatric hospital or chemical
2504 dependency hospital does not participate in the Medicaid program
2505 (Section 43-13-101 et seq.) at the time of the application for the
2506 certificate of need and the owner of the hospital, psychiatric
2507 hospital or chemical dependency hospital agrees in writing that
2508 the hospital, psychiatric hospital or chemical dependency hospital
2509 will not at any time participate in the Medicaid program or admit
2510 or keep any patients who are participating in the Medicaid program
2511 in the hospital, psychiatric hospital or chemical dependency
2512 hospital. This written agreement by the recipient of the
2513 certificate of need shall be fully binding on any subsequent owner
2514 of the hospital, psychiatric hospital or chemical dependency
2515 hospital, if the ownership of the facility is transferred at any
2516 time after the issuance of the certificate of need. Agreement
2517 that the hospital, psychiatric hospital or chemical dependency
2518 hospital will not participate in the Medicaid program shall be a
2519 condition of the issuance of a certificate of need to any person
2520 under this subparagraph (a)(i), and if such hospital, psychiatric
2521 hospital or chemical dependency hospital at any time after the
2522 issuance of the certificate of need, regardless of the ownership
2523 of the facility, participates in the Medicaid program or admits or
2524 keeps any patients in the hospital, psychiatric hospital or
2525 chemical dependency hospital who are participating in the Medicaid
2526 program, the State Department of Health shall revoke the
2527 certificate of need, if it is still outstanding, and shall deny or
2528 revoke the license of the hospital, psychiatric hospital or
2529 chemical dependency hospital, at the time that the department
2530 determines, after a hearing complying with due process, that the
2531 hospital, psychiatric hospital or chemical dependency hospital has

2532 failed to comply with any of the conditions upon which the
2533 certificate of need was issued, as provided in this subparagraph
2534 and in the written agreement by the recipient of the certificate
2535 of need.

2536 (ii) The department may issue a certificate of
2537 need for the conversion of existing beds in a county hospital in
2538 Choctaw County from acute care beds to child/adolescent chemical
2539 dependency beds. For purposes of this subparagraph, the
2540 provisions of Section 41-7-193(1) requiring substantial compliance
2541 with the projection of need as reported in the current State
2542 Health Plan is waived. The total number of beds that may be
2543 authorized under authority of this subparagraph shall not exceed
2544 twenty (20) beds. There shall be no prohibition or restrictions
2545 on participation in the Medicaid program (Section 43-13-101 et
2546 seq.) for the hospital receiving the certificate of need
2547 authorized under this subparagraph (a)(ii) or for the beds
2548 converted pursuant to the authority of that certificate of need.

2549 (iii) The department may issue a certificate or
2550 certificates of need for the construction or expansion of
2551 child/adolescent psychiatric beds or the conversion of other beds
2552 to child/adolescent psychiatric beds in Warren County. For
2553 purposes of this subparagraph, the provisions of Section
2554 41-7-193(1) requiring substantial compliance with the projection
2555 of need as reported in the current State Health Plan are waived.
2556 The total number of beds that may be authorized under the
2557 authority of this subparagraph shall not exceed twenty (20) beds.
2558 There shall be no prohibition or restrictions on participation in
2559 the Medicaid program (Section 43-13-101 et seq.) for the person
2560 receiving the certificate of need authorized under this
2561 subparagraph (a)(iii) or for the beds converted pursuant to the
2562 authority of that certificate of need.

2563 If by January 1, 2002, there has been no significant
2564 commencement of construction of the beds authorized under this

2565 subparagraph (a)(iii), or no significant action taken to convert
2566 existing beds to the beds authorized under this subparagraph, then
2567 the certificate of need that was previously issued under this
2568 subparagraph shall expire. If the previously issued certificate
2569 of need expires, the department may accept applications for
2570 issuance of another certificate of need for the beds authorized
2571 under this subparagraph, and may issue a certificate of need to
2572 authorize the construction, expansion or conversion of the beds
2573 authorized under this subparagraph.
2574 (iv) The department shall issue a certificate of
2575 need to the Region 7 Mental Health/Retardation Commission for the
2576 construction or expansion of child/adolescent psychiatric beds or
2577 the conversion of other beds to child/adolescent psychiatric beds
2578 in any of the counties served by the commission. For purposes of
2579 this subparagraph, the provisions of Section 41-7-193(1) requiring
2580 substantial compliance with the projection of need as reported in
2581 the current State Health Plan is waived. The total number of beds
2582 that may be authorized under the authority of this subparagraph
2583 shall not exceed twenty (20) beds. There shall be no prohibition
2584 or restrictions on participation in the Medicaid program (Section
2585 43-13-101 et seq.) for the person receiving the certificate of
2586 need authorized under this subparagraph (a)(iv) or for the beds
2587 converted pursuant to the authority of that certificate of need.
2588 (v) The department may issue a certificate of need
2589 to any county hospital located in Leflore County for the
2590 construction or expansion of adult psychiatric beds or the
2591 conversion of other beds to adult psychiatric beds, not to exceed
2592 twenty (20) beds, provided that the recipient of the certificate
2593 of need agrees in writing that the adult psychiatric beds will not
2594 at any time be certified for participation in the Medicaid program
2595 and that the hospital will not admit or keep any patients who are
2596 participating in the Medicaid program in any of such adult
2597 psychiatric beds. This written agreement by the recipient of the

2598 certificate of need shall be fully binding on any subsequent owner
2599 of the hospital if the ownership of the hospital is transferred at
2600 any time after the issuance of the certificate of need. Agreement
2601 that the adult psychiatric beds will not be certified for
2602 participation in the Medicaid program shall be a condition of the
2603 issuance of a certificate of need to any person under this
2604 subparagraph (a)(v), and if such hospital at any time after the
2605 issuance of the certificate of need, regardless of the ownership
2606 of the hospital, has any of such adult psychiatric beds certified
2607 for participation in the Medicaid program or admits or keeps any
2608 Medicaid patients in such adult psychiatric beds, the State
2609 Department of Health shall revoke the certificate of need, if it
2610 is still outstanding, and shall deny or revoke the license of the
2611 hospital at the time that the department determines, after a
2612 hearing complying with due process, that the hospital has failed
2613 to comply with any of the conditions upon which the certificate of
2614 need was issued, as provided in this subparagraph and in the
2615 written agreement by the recipient of the certificate of need.
2616 (vi) The department may issue a certificate or
2617 certificates of need for the expansion of child psychiatric beds
2618 or the conversion of other beds to child psychiatric beds at the
2619 University of Mississippi Medical Center. For purposes of this
2620 subparagraph (a)(vi), the provision of Section 41-7-193(1)
2621 requiring substantial compliance with the projection of need as
2622 reported in the current State Health Plan is waived. The total
2623 number of beds that may be authorized under the authority of this
2624 subparagraph (a)(vi) shall not exceed fifteen (15) beds. There
2625 shall be no prohibition or restrictions on participation in the
2626 Medicaid program (Section 43-13-101 et seq.) for the hospital
2627 receiving the certificate of need authorized under this
2628 subparagraph (a)(vi) or for the beds converted pursuant to the
2629 authority of that certificate of need.

2630 (b) From and after July 1, 1990, no hospital,
2631 psychiatric hospital or chemical dependency hospital shall be
2632 authorized to add any child/adolescent psychiatric or
2633 child/adolescent chemical dependency beds or convert any beds of
2634 another category to child/adolescent psychiatric or
2635 child/adolescent chemical dependency beds without a certificate of
2636 need under the authority of subsection (1)(c) of this section.
2637 (5) The department may issue a certificate of need to a
2638 county hospital in Winston County for the conversion of fifteen
2639 (15) acute care beds to geriatric psychiatric care beds.
2640 (6) The State Department of Health shall issue a certificate
2641 of need to a Mississippi corporation qualified to manage a
2642 long-term care hospital as defined in Section 41-7-173(h)(xii) in
2643 Harrison County, not to exceed eighty (80) beds, including any
2644 necessary renovation or construction required for licensure and
2645 certification, provided that the recipient of the certificate of
2646 need agrees in writing that the long-term care hospital will not
2647 at any time participate in the Medicaid program (Section 43-13-101
2648 et seq.) or admit or keep any patients in the long-term care
2649 hospital who are participating in the Medicaid program. This
2650 written agreement by the recipient of the certificate of need
2651 shall be fully binding on any subsequent owner of the long-term
2652 care hospital, if the ownership of the facility is transferred at
2653 any time after the issuance of the certificate of need. Agreement
2654 that the long-term care hospital will not participate in the
2655 Medicaid program shall be a condition of the issuance of a
2656 certificate of need to any person under this subsection (6), and
2657 if such long-term care hospital at any time after the issuance of
2658 the certificate of need, regardless of the ownership of the
2659 facility, participates in the Medicaid program or admits or keeps
2660 any patients in the facility who are participating in the Medicaid
2661 program, the State Department of Health shall revoke the
2662 certificate of need, if it is still outstanding, and shall deny or

2663 revoke the license of the long-term care hospital, at the time
2664 that the department determines, after a hearing complying with due
2665 process, that the facility has failed to comply with any of the
2666 conditions upon which the certificate of need was issued, as
2667 provided in this subsection and in the written agreement by the
2668 recipient of the certificate of need. For purposes of this
2669 subsection, the provision of Section 41-7-193(1) requiring
2670 substantial compliance with the projection of need as reported in
2671 the current State Health Plan is hereby waived.
2672 (7) The State Department of Health may issue a certificate
2673 of need to any hospital in the state to utilize a portion of its
2674 beds for the "swing-bed" concept. Any such hospital must be in
2675 conformance with the federal regulations regarding such swing-bed
2676 concept at the time it submits its application for a certificate
2677 of need to the State Department of Health, except that such
2678 hospital may have more licensed beds or a higher average daily
2679 census (ADC) than the maximum number specified in federal
2680 regulations for participation in the swing-bed program. Any
2681 hospital meeting all federal requirements for participation in the
2682 swing-bed program which receives such certificate of need shall
2683 render services provided under the swing-bed concept to any
2684 patient eligible for Medicare (Title XVIII of the Social Security
2685 Act) who is certified by a physician to be in need of such
2686 services, and no such hospital shall permit any patient who is
2687 eligible for both Medicaid and Medicare or eligible only for
2688 Medicaid to stay in the swing beds of the hospital for more than
2689 thirty (30) days per admission unless the hospital receives prior
2690 approval for such patient from the Division of Medicaid, Office of
2691 the Governor. Any hospital having more licensed beds or a higher
2692 average daily census (ADC) than the maximum number specified in
2693 federal regulations for participation in the swing-bed program
2694 which receives such certificate of need shall develop a procedure
2695 to insure that before a patient is allowed to stay in the swing

2696 beds of the hospital, there are no vacant nursing home beds
2697 available for that patient located within a fifty-mile radius of
2698 the hospital. When any such hospital has a patient staying in the
2699 swing beds of the hospital and the hospital receives notice from a
2700 nursing home located within such radius that there is a vacant bed
2701 available for that patient, the hospital shall transfer the
2702 patient to the nursing home within a reasonable time after receipt
2703 of the notice. Any hospital which is subject to the requirements
2704 of the two (2) preceding sentences of this subsection may be
2705 suspended from participation in the swing-bed program for a
2706 reasonable period of time by the State Department of Health if the
2707 department, after a hearing complying with due process, determines
2708 that the hospital has failed to comply with any of those
2709 requirements.

2710 (8) The Department of Health shall not grant approval for or
2711 issue a certificate of need to any person proposing the new
2712 construction of, addition to or expansion of a health care
2713 facility as defined in subparagraph (viii) of Section 41-7-173(h).

2714 (9) The Department of Health shall not grant approval for or
2715 issue a certificate of need to any person proposing the
2716 establishment of, or expansion of the currently approved territory
2717 of, or the contracting to establish a home office, subunit or
2718 branch office within the space operated as a health care facility
2719 as defined in Section 41-7-173(h)(i) through (viii) by a health
2720 care facility as defined in subparagraph (ix) of Section
2721 41-7-173(h).

2722 (10) Health care facilities owned and/or operated by the
2723 state or its agencies are exempt from the restraints in this
2724 section against issuance of a certificate of need if such addition
2725 or expansion consists of repairing or renovation necessary to
2726 comply with the state licensure law. This exception shall not
2727 apply to the new construction of any building by such state
2728 facility. This exception shall not apply to any health care

2729 facilities owned and/or operated by counties, municipalities,
2730 districts, unincorporated areas, other defined persons, or any
2731 combination thereof.
2732 (11) The new construction, renovation or expansion of or
2733 addition to any health care facility defined in subparagraph (ii)
2734 (psychiatric hospital), subparagraph (iv) (skilled nursing
2735 facility), subparagraph (vi) (intermediate care facility),
2736 subparagraph (viii) (intermediate care facility for the mentally
2737 retarded) and subparagraph (x) (psychiatric residential treatment
2738 facility) of Section 41-7-173(h) which is owned by the State of
2739 Mississippi and under the direction and control of the State
2740 Department of Mental Health, and the addition of new beds or the
2741 conversion of beds from one category to another in any such
2742 defined health care facility which is owned by the State of
2743 Mississippi and under the direction and control of the State
2744 Department of Mental Health, shall not require the issuance of a
2745 certificate of need under Section 41-7-171 et seq.,
2746 notwithstanding any provision in Section 41-7-171 et seq. to the
2747 contrary.
2748 (12) The new construction, renovation or expansion of or
2749 addition to any veterans homes or domiciliaries for eligible
2750 veterans of the State of Mississippi as authorized under Section
2751 35-1-19 shall not require the issuance of a certificate of need,
2752 notwithstanding any provision in Section 41-7-171 et seq. to the
2753 contrary.
2754 (13) The new construction of a nursing facility or nursing
2755 facility beds or the conversion of other beds to nursing facility
2756 beds shall not require the issuance of a certificate of need,
2757 notwithstanding any provision in Section 41-7-171 et seq. to the
2758 contrary, if the conditions of this subsection are met.
2759 (a) Before any construction or conversion may be
2760 undertaken without a certificate of need, the owner of the nursing
2761 facility, in the case of an existing facility, or the applicant to

2762 construct a nursing facility, in the case of new construction,
2763 first must file a written notice of intent and sign a written
2764 agreement with the State Department of Health that the entire
2765 nursing facility will not at any time participate in or have any
2766 beds certified for participation in the Medicaid program (Section
2767 43-13-101 et seq.), will not admit or keep any patients in the
2768 nursing facility who are participating in the Medicaid program,
2769 and will not submit any claim for Medicaid reimbursement for any
2770 patient in the facility. This written agreement by the owner or
2771 applicant shall be a condition of exercising the authority under
2772 this subsection without a certificate of need, and the agreement
2773 shall be fully binding on any subsequent owner of the nursing
2774 facility if the ownership of the facility is transferred at any
2775 time after the agreement is signed. After the written agreement
2776 is signed, the Division of Medicaid and the State Department of
2777 Health shall not certify any beds in the nursing facility for
2778 participation in the Medicaid program. If the nursing facility
2779 violates the terms of the written agreement by participating in
2780 the Medicaid program, having any beds certified for participation
2781 in the Medicaid program, admitting or keeping any patient in the
2782 facility who is participating in the Medicaid program, or
2783 submitting any claim for Medicaid reimbursement for any patient in
2784 the facility, the State Department of Health shall revoke the
2785 license of the nursing facility at the time that the department
2786 determines, after a hearing complying with due process, that the
2787 facility has violated the terms of the written agreement.
2788 (b) For the purposes of this subsection, participation
2789 in the Medicaid program by a nursing facility includes Medicaid
2790 reimbursement of coinsurance and deductibles for recipients who
2791 are qualified Medicare beneficiaries and/or those who are dually
2792 eligible. Any nursing facility exercising the authority under
2793 this subsection may not bill or submit a claim to the Division of

2794 Medicaid for services to qualified Medicare beneficiaries and/or
2795 those who are dually eligible.

2796 (c) The new construction of a nursing facility or
2797 nursing facility beds or the conversion of other beds to nursing
2798 facility beds described in this section must be either a part of a
2799 completely new continuing care retirement community, as described
2800 in the latest edition of the Mississippi State Health Plan, or an
2801 addition to existing personal care and independent living
2802 components, and so that the completed project will be a continuing
2803 care retirement community, containing (i) independent living
2804 accommodations, (ii) personal care beds, and (iii) the nursing
2805 home facility beds. The three (3) components must be located on a
2806 single site and be operated as one (1) inseparable facility. The
2807 nursing facility component must contain a minimum of thirty (30)
2808 beds. Any nursing facility beds authorized by this section will
2809 not be counted against the bed need set forth in the State Health
2810 Plan, as identified in Section 41-7-171, et seq.

2811 This subsection (13) shall stand repealed from and after July
2812 1, 2005.

2813 (14) The State Department of Health shall issue a
2814 certificate of need to any hospital which is currently licensed
2815 for two hundred fifty (250) or more acute care beds and is located
2816 in any general hospital service area not having a comprehensive
2817 cancer center, for the establishment and equipping of such a
2818 center which provides facilities and services for outpatient
2819 radiation oncology therapy, outpatient medical oncology therapy,
2820 and appropriate support services including the provision of
2821 radiation therapy services. The provision of Section 41-7-193(1)
2822 regarding substantial compliance with the projection of need as
2823 reported in the current State Health Plan is waived for the
2824 purpose of this subsection.

2825 (15) The State Department of Health may authorize the
2826 transfer of hospital beds, not to exceed sixty (60) beds, from the

2827 North Panola Community Hospital to the South Panola Community
2828 Hospital. The authorization for the transfer of those beds shall
2829 be exempt from the certificate of need review process.
2830 (16) Nothing in this section or in any other provision of
2831 Section 41-7-171 et seq. shall prevent any nursing facility from
2832 designating an appropriate number of existing beds in the facility
2833 as beds for providing care exclusively to patients with
2834 Alzheimer's disease.
2835 (17) The State Department of Health shall issue, upon
2836 application therefor, a certificate of need to the sole Medicare
2837 certified hospital of at least one hundred fifty (150) licensed
2838 beds for comprehensive medical rehabilitation services as defined
2839 in Section 41-7-173(h)(xiii) in the following counties: Alcorn,
2840 Coahoma, Lafayette, Lowndes, Grenada, Jones and Jackson. The
2841 recipient hospital of the comprehensive medical rehabilitation
2842 services certificate of need shall agree in writing that the
2843 hospital will not participate in the Medicaid program, Section
2844 43-13-101 et seq., for any patient admitted to the stated service.
2845 **SECTION 11.** Section 43-13-407, Mississippi Code of 1972, is
2846 amended as follows:
2847 43-13-407. (1) In accordance with the purposes of this
2848 article, there is established in the State Treasury the Health
2849 Care Expendable Fund, into which shall be transferred from the
2850 Health Care Trust Fund the following sums:
2851 (a) In fiscal year 2000, Fifty Million Dollars
2852 ($50,000,000.00);
2853 (b) In fiscal year 2001, Fifty-five Million Dollars
2854 ($55,000,000.00);
2855 (c) In fiscal year 2002, Sixty Million Five Hundred
2856 Thousand Dollars ($60,500,000.00);
2857 (d) In fiscal year 2003, Sixty-six Million Five Hundred
2858 Fifty Thousand Dollars ($66,550,000.00);

2859 (e) In fiscal year 2004 and each subsequent fiscal
2860 year, a sum equal to the average annual amount of the income from
2861 the investment of the funds in the Health Care Trust Fund since
2862 July 1, 1999.

2863 (2) In any fiscal year in which interest and dividends from
2864 the investment of the funds in the Health Care Trust Fund are not
2865 sufficient to fund the full amount of the annual transfer into the
2866 Health Care Expendable Fund as required in subsection (1) of this
2867 section, the State Treasurer shall transfer from tobacco
2868 settlement installment payments an amount that is sufficient to
2869 fully fund the amount of the annual transfer.

2870 (3) The State Treasurer shall transfer One Hundred Million
2871 Dollars ($100,000,000.00) of the 2002 tobacco settlement
2872 installment payment, and up to One Hundred Million
2873 ($100,000,000.00) of the future annual tobacco settlement
2874 installment payments, into the Health Care Expendable Fund, and
2875 said monies shall be appropriated by the Legislature to the
2876 Division of Medicaid to match federal funds pursuant to the
2877 federal waiver programs authorized in Sections 43-13-115 and
2878 43-13-117, Mississippi Code of 1972.

2879 (4) All income from the investment of the funds in the
2880 Health Care Expendable Fund shall be credited to the account of
2881 the Health Care Expendable Fund. Any funds in the Health Care
2882 Expendable Fund at the end of a fiscal year shall not lapse into
2883 the State General Fund.

2884 (5) The funds in the Health Care Expendable Fund shall be
2885 available for expenditure pursuant to specific appropriation by
2886 the Legislature beginning in fiscal year 2000, and shall be
2887 expended exclusively for health care purposes.

2888 **SECTION 12.** Section 43-13-405, Mississippi Code of 1972, is
2889 amended as follows:

2890 43-13-405. (1) In accordance with the purposes of this
2891 article, there is established in the State Treasury the Health

2892 Care Trust Fund, into which shall be deposited Two Hundred Eighty
2893 Million Dollars ($280,000,000.00) of the funds received by the
2894 State of Mississippi as a result of the tobacco settlement as of
2895 the end of fiscal year 1999, and all tobacco settlement
2896 installment payments made in subsequent years for which the use or
2897 purpose for expenditure is not restricted by the terms of the
2898 settlement, except as otherwise provided in Sections 43-13-407(2)
2899 and 43-13-407(3). All income from the investment of the funds in
2900 the Health Care Trust Fund shall be credited to the account of the
2901 Health Care Trust Fund. The funds in the Health Care Trust Fund
2902 at the end of a fiscal year shall not lapse into the State General
2903 Fund.

2904 (2) The Health Care Trust Fund shall remain inviolate and
2905 shall never be expended, except as provided in this article. The
2906 Legislature shall appropriate from the Health Care Trust Fund such
2907 sums as are necessary to recoup any funds lost as a result of any
2908 of the following actions:

2909 (a) The federal Health Care Finance Administration, or
2910 other agency of the federal government, is successful in recouping
2911 tobacco settlement funds from the State of Mississippi;

2912 (b) The federal share of funds for the support of the
2913 Mississippi Medicaid Program is reduced directly or indirectly as
2914 a result of the tobacco settlement;

2915 (c) Federal funding for any other program is reduced as
2916 a result of the tobacco settlement; or

2917 (d) Tobacco cessation programs are mandated by the
2918 federal government or court order.

2919 **SECTION 13.** This act shall take effect and be in force from
2920 and after July 1, 2002.

ST: "Mississippians' Access to Healthcare Act of 2002"; enact.