MISSISSIPPI LEGISLATURE REGULAR SESSION 2002

By: Senator(s) Huggins

To: Public Health and Welfare; Appropriations

SENATE BILL NO. 2982

1 AN ACT RELATING TO THE MISSISSIPPI MEDICAID LAW AND PROVIDING
2 HEALTH CARE; TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972,
3 TO AUTHORIZE UNLIMITED DAY REIMBURSEMENT FOR DISPROPORTIONATE
4 SHARE PROGRAM HOSPITALS FOR ELIGIBLE CHILDREN UNDER THE AGE OF SIX
5 ONLY IF CERTIFIED AS MEDICALLY NECESSARY, TO AUTHORIZE THE
6 DIVISION OF MEDICAID TO ESTABLISH A MEDICARE UPPER PAYMENT LIMITS
7 PROGRAM FOR OUTPATIENT HOSPITAL SERVICES, TO AUTHORIZE THE
8 DIVISION OF MEDICAID TO ESTABLISH A MEDICARE UPPER PAYMENT LIMITS
9 PROGRAM FOR NURSING FACILITY SERVICES, TO REQUIRE THAT NURSING
10 FACILITIES THAT PARTICIPATE IN THE MEDICAID PROGRAM ALSO BE
11 CERTIFIED TO PARTICIPATE IN THE MEDICARE PROGRAM, TO DELETE
12 SPECIFIC FEE INCREASES FOR PERIODIC SCREENING AND DIAGNOSTIC
13 SERVICES, TO REVISE THE CONDITIONS FOR REIMBURSEMENT OF THE COST
14 OF EYEGLASSES FOR RECIPIENTS, TO CLARIFY THE REQUIREMENT FOR
15 DISPROPORTIONATE SHARE PROGRAM HOSPITALS TO PARTICIPATE IN THE
16 FEDERAL INTERGOVERNMENTAL TRANSFER PROGRAM, TO CHANGE CERTAIN
17 REFERENCES TO THE FEDERAL INDIVIDUALS WITH DISABILITIES EDUCATION
18 ACT, TO AUTHORIZE MEDICAID REIMBURSEMENT TO RURAL HEALTH CENTERS
19 FOR AMBULATORY SERVICES, TO AUTHORIZE MEDICAID REIMBURSEMENT TO
20 CHIROPRACTORS FOR X-RAYS PERFORMED TO DOCUMENT CONDITIONS, AND TO
21 AUTHORIZE THE DIVISION TO DEVELOP AND IMPLEMENT A DISEASE
22 MANAGEMENT PROGRAM; TO AMEND SECTION 43-13-121, MISSISSIPPI CODE
23 OF 1972, TO CLARIFY AND REVISE THE CONDITIONS FOR DENYING OR
24 REVOKING PROVIDER ENROLLMENT IN THE MEDICAID PROGRAM; TO AMEND
25 SECTION 43-13-123, MISSISSIPPI CODE OF 1972, TO CLARIFY THAT THE
26 DIVISION SHALL OBTAIN SERVICES PURSUANT TO REGULATIONS OF THE
27 PERSONAL SERVICE CONTRACT REVIEW BOARD; TO AMEND SECTION
28 43-13-145, MISSISSIPPI CODE OF 1972, TO CLARIFY THAT THE MEDICAID
29 ASSESSMENT IS TO BE ON ALL LICENSED OR CERTIFIED NURSING FACILITY
30 BEDS IN THE STATE; TO AMEND SECTION 41-7-191, MISSISSIPPI CODE OF
31 1972, TO DELETE THE REQUIREMENT THAT THE DIVISION OF MEDICAID
32 FURNISH A CERTAIN RESIDENTIAL FACILITY THE NAMES AND MEDICAL
33 INFORMATION ABOUT RECIPIENTS RECEIVING SERVICES OUT OF STATE; TO
34 AMEND SECTIONS 43-11-19 AND 43-63-21, MISSISSIPPI CODE OF 1972, TO
35 CLARIFY THAT NURSING HOME SURVEYS AND REPORTS SHALL BE
36 CONFIDENTIAL EXCEPT IN ADMINISTRATIVE LICENSURE CASES; TO AMEND
37 SECTION 43-11-13, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT
38 NOTHING IN THE NURSING HOME STATUTES OR REGULATIONS SHALL
39 ESTABLISH A MEDICAL STANDARD OF CARE; TO AMEND SECTION 15-1-36,
40 MISSISSIPPI CODE OF 1972, TO ESTABLISH A LONG-TERM CARE STATUTE OF
41 LIMITATIONS; TO AMEND SECTION 43-11-7, MISSISSIPPI CODE OF 1972,
42 TO CLARIFY APPLICANTS FOR A NURSING HOME LICENSE; TO AMEND
43 SECTIONS 43-7-53 AND 43-7-61, MISSISSIPPI CODE OF 1972, TO CLARIFY
44 QUALIFICATIONS FOR LONG-TERM CARE OMBUDSMEN; TO PROVIDE VENUE FOR
45 BRINGING A CAUSE OF ACTION AGAINST NURSING HOMES AND OTHER
46 LONG-TERM CARE PROVIDERS; AND FOR RELATED PURPOSES.

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

48 **SECTION 1.** Section 43-13-117, Mississippi Code of 1972, is

49 amended as follows:

50 43-13-117. Medical assistance as authorized by this article
51 shall include payment of part or all of the costs, at the
52 discretion of the division or its successor, with approval of the
53 Governor, of the following types of care and services rendered to
54 eligible applicants who shall have been determined to be eligible
55 for such care and services, within the limits of state
56 appropriations and federal matching funds:

57 (1) Inpatient hospital services.

58 (a) The division shall allow thirty (30) days of
59 inpatient hospital care annually for all Medicaid recipients.
60 Precertification of inpatient days must be obtained as required by
61 the division. The division shall be authorized to allow unlimited
62 days in disproportionate hospitals as defined by the division for
63 eligible infants under the age of six (6) years if certified as
64 medically necessary as required by the division.

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

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

79 (2) Outpatient hospital services.

80 (a) Provided that where the same services are
81 reimbursed as clinic services, the division may revise the rate or
82 methodology of outpatient reimbursement to maintain consistency,

83 efficiency, economy and quality of care. The division shall
84 develop a Medicaid-specific cost-to-charge ratio calculation from
85 data provided by hospitals to determine an allowable rate payment
86 for outpatient hospital services, and shall submit a report
87 thereon to the Medical Advisory Committee on or before December 1,
88 1999. The committee shall make a recommendation on the specific
89 cost-to-charge reimbursement method for outpatient hospital
90 services to the 2000 Regular Session of the Legislature.
91 (b) In addition to reimbursement methodology for
92 outpatient hospital services, the division may establish a
93 Medicare upper payment limits program for outpatient hospital
94 services in accordance with applicable federal law and
95 regulations. The division may assess each hospital for the sole
96 purpose of financing the state portion of the Medicare upper
97 payment limits program for outpatient hospital services based on
98 appropriate methodology consistent with federal law and
99 regulations. This assessment will remain in effect as long as the
100 state participates in a Medicare upper payment limits program for
101 outpatient hospital services.
102 (3) Laboratory and x-ray services.
103 (4) Nursing facility services.
104 (a) The division shall make full payment to
105 nursing facilities for each day, not exceeding fifty-two (52) days
106 per year, that a patient is absent from the facility on home
107 leave. Payment may be made for the following home leave days in
108 addition to the fifty-two-day limitation: Christmas, the day
109 before Christmas, the day after Christmas, Thanksgiving, the day
110 before Thanksgiving and the day after Thanksgiving.
111 (b) From and after July 1, 1997, the division
112 shall implement the integrated case-mix payment and quality
113 monitoring system, which includes the fair rental system for
114 property costs and in which recapture of depreciation is
115 eliminated. The division may reduce the payment for hospital

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

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

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

149 (e) The division shall develop and implement, not
150 later than January 1, 2001, a case-mix payment add-on determined
151 by time studies and other valid statistical data which will
152 reimburse a nursing facility for the additional cost of caring for
153 a resident who has a diagnosis of Alzheimer's or other related
154 dementia and exhibits symptoms that require special care. Any
155 such case-mix add-on payment shall be supported by a determination
156 of additional cost. The division shall also develop and implement
157 as part of the fair rental reimbursement system for nursing
158 facility beds, an Alzheimer's resident bed depreciation enhanced
159 reimbursement system which will provide an incentive to encourage
160 nursing facilities to convert or construct beds for residents with
161 Alzheimer's or other related dementia.
162 (f) The Division of Medicaid shall develop and
163 implement a referral process for long-term care alternatives for
164 Medicaid beneficiaries and applicants. No Medicaid beneficiary
165 shall be admitted to a Medicaid-certified nursing facility unless
166 a licensed physician certifies that nursing facility care is
167 appropriate for that person on a standardized form to be prepared
168 and provided to nursing facilities by the Division of Medicaid.
169 The physician shall forward a copy of that certification to the
170 Division of Medicaid within twenty-four (24) hours after it is
171 signed by the physician. Any physician who fails to forward the
172 certification to the Division of Medicaid within the time period
173 specified in this paragraph shall be ineligible for Medicaid
174 reimbursement for any physician's services performed for the
175 applicant. The Division of Medicaid shall determine, through an
176 assessment of the applicant conducted within two (2) business days
177 after receipt of the physician's certification, whether the
178 applicant also could live appropriately and cost-effectively at
179 home or in some other community-based setting if home- or
180 community-based services were available to the applicant. The
181 time limitation prescribed in this paragraph shall be waived in

182 cases of emergency. If the Division of Medicaid determines that a
183 home- or other community-based setting is appropriate and
184 cost-effective, the division shall:

185 (i) Advise the applicant or the applicant's
186 legal representative that a home- or other community-based setting
187 is appropriate;

188 (ii) Provide a proposed care plan and inform
189 the applicant or the applicant's legal representative regarding
190 the degree to which the services in the care plan are available in
191 a home- or in other community-based setting rather than nursing
192 facility care; and

193 (iii) Explain that such plan and services are
194 available only if the applicant or the applicant's legal
195 representative chooses a home- or community-based alternative to
196 nursing facility care, and that the applicant is free to choose
197 nursing facility care.

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

203 Placement in a nursing facility may not be denied by the
204 division if home- or community-based services that would be more
205 appropriate than nursing facility care are not actually available,
206 or if the applicant chooses not to receive the appropriate home-
207 or community-based services.

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

212 The division shall make full payment for long-term care
213 alternative services.

214 The division shall apply for necessary federal waivers to
215 assure that additional services providing alternatives to nursing
216 facility care are made available to applicants for nursing
217 facility care.
218 <u>(g) In addition to reimbursement methodology for</u>
219 <u>nursing facility services, the division may establish a Medicare</u>
220 <u>upper payment limits program for nursing facility services in</u>
221 <u>accordance with applicable federal law and regulations. The</u>
222 <u>division may assess each nursing facility for the sole purpose of</u>
223 <u>financing the state portion of the Medicare upper payment limits</u>
224 <u>program for nursing facility services based on appropriate</u>
225 <u>methodology consistent with federal law and regulations. This</u>
226 <u>assessment will remain in effect as long as the state participates</u>
227 <u>in a Medicare upper payment limits program for nursing facility</u>
228 <u>services.</u>
229 <u>(h) Effective July 1, 2003, all Title XIX nursing</u>
230 <u>facilities must be Title XVIII certified in order to participate</u>
231 <u>in the Medicaid program.</u>
232 (5) Periodic screening and diagnostic services for
233 individuals under age twenty-one (21) years as are needed to
234 identify physical and mental defects and to provide health care
235 treatment and other measures designed to correct or ameliorate
236 defects and physical and mental illness and conditions discovered
237 by the screening services regardless of whether these services are
238 included in the state plan. The division may include in its
239 periodic screening and diagnostic program those discretionary
240 services authorized under the federal regulations adopted to
241 implement Title XIX of the federal Social Security Act, as
242 amended. The division, in obtaining physical therapy services,
243 occupational therapy services, and services for individuals with
244 speech, hearing and language disorders, may enter into a
245 cooperative agreement with the State Department of Education for
246 the provision of such services to handicapped students by public

247 school districts using state funds which are provided from the
248 appropriation to the Department of Education to obtain federal
249 matching funds through the division. The division, in obtaining
250 medical and psychological evaluations for children in the custody
251 of the State Department of Human Services may enter into a
252 cooperative agreement with the State Department of Human Services
253 for the provision of such services using state funds which are
254 provided from the appropriation to the Department of Human
255 Services to obtain federal matching funds through the division.
256 * * *
257 (6) Physician's services. The division shall allow
258 twelve (12) physician visits annually. All fees for physicians'
259 services that are covered only by Medicaid shall be reimbursed at
260 ninety percent (90%) of the rate established on January 1, 1999,
261 and as adjusted each January thereafter, under Medicare (Title
262 XVIII of the Social Security Act, as amended), and which shall in
263 no event be less than seventy percent (70%) of the rate
264 established on January 1, 1994. All fees for physicians' services
265 that are covered by both Medicare and Medicaid shall be reimbursed
266 at ten percent (10%) of the adjusted Medicare payment established
267 on January 1, 1999, and as adjusted each January thereafter, under
268 Medicare (Title XVIII of the Social Security Act, as amended), and
269 which shall in no event be less than seventy percent (70%) of the
270 adjusted Medicare payment established on January 1, 1994.
271 (7) (a) Home health services for eligible persons, not
272 to exceed in cost the prevailing cost of nursing facility
273 services, not to exceed sixty (60) visits per year. All home
274 health visits must be precertified as required by the division.
275 (b) Repealed.
276 (8) Emergency medical transportation services. On
277 January 1, 1994, emergency medical transportation services shall
278 be reimbursed at seventy percent (70%) of the rate established
279 under Medicare (Title XVIII of the Social Security Act, as

280 amended). "Emergency medical transportation services" shall mean,
281 but shall not be limited to, the following services by a properly
282 permitted ambulance operated by a properly licensed provider in
283 accordance with the Emergency Medical Services Act of 1974
284 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
285 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
286 (vi) disposable supplies, (vii) similar services.
287 (9) Legend and other drugs as may be determined by the
288 division. The division may implement a program of prior approval
289 for drugs to the extent permitted by law. Payment by the division
290 for covered multiple source drugs shall be limited to the lower of
291 the upper limits established and published by the Health Care
292 Financing Administration (HCFA) plus a dispensing fee of Four
293 Dollars and Ninety-one Cents ($4.91), or the estimated acquisition
294 cost (EAC) as determined by the division plus a dispensing fee of
295 Four Dollars and Ninety-one Cents ($4.91), or the providers' usual
296 and customary charge to the general public. The division shall
297 allow ten (10) prescriptions per month for noninstitutionalized
298 Medicaid recipients.
299 Payment for other covered drugs, other than multiple source
300 drugs with HCFA upper limits, shall not exceed the lower of the
301 estimated acquisition cost as determined by the division plus a
302 dispensing fee of Four Dollars and Ninety-one Cents ($4.91) or the
303 providers' usual and customary charge to the general public.
304 Payment for nonlegend or over-the-counter drugs covered on
305 the division's formulary shall be reimbursed at the lower of the
306 division's estimated shelf price or the providers' usual and
307 customary charge to the general public. No dispensing fee shall
308 be paid.
309 The division shall develop and implement a program of payment
310 for additional pharmacist services, with payment to be based on
311 demonstrated savings, but in no case shall the total payment
312 exceed twice the amount of the dispensing fee.

313 As used in this paragraph (9), "estimated acquisition cost"
314 means the division's best estimate of what price providers
315 generally are paying for a drug in the package size that providers
316 buy most frequently. Product selection shall be made in
317 compliance with existing state law; however, the division may
318 reimburse as if the prescription had been filled under the generic
319 name. The division may provide otherwise in the case of specified
320 drugs when the consensus of competent medical advice is that
321 trademarked drugs are substantially more effective.

322 (10) Dental care that is an adjunct to treatment of an
323 acute medical or surgical condition; services of oral surgeons and
324 dentists in connection with surgery related to the jaw or any
325 structure contiguous to the jaw or the reduction of any fracture
326 of the jaw or any facial bone; and emergency dental extractions
327 and treatment related thereto. On July 1, 1999, all fees for
328 dental care and surgery under authority of this paragraph (10)
329 shall be increased to one hundred sixty percent (160%) of the
330 amount of the reimbursement rate that was in effect on June 30,
331 1999. It is the intent of the Legislature to encourage more
332 dentists to participate in the Medicaid program.

333 (11) Eyeglasses for all Medicaid beneficiaries who have
334 (a) had *** * *** surgery on the eyeball or ocular muscle which
335 results in a vision change for which eyeglasses or a change in
336 eyeglasses is medically indicated within six (6) months of the
337 surgery and is in accordance with policies established by the
338 division, or (b) one (1) pair every three (3) years and in
339 accordance with policies established by the division. In either
340 instance, the eyeglasses must be prescribed by a physician skilled
341 in the diseases of the eye or an optometrist, whichever the
342 beneficiary may select.

343 (12) Intermediate care facility services.

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

346 day, not exceeding eighty-four (84) days per year, that a patient
347 is absent from the facility on home leave. Payment may be made
348 for the following home leave days in addition to the
349 eighty-four-day limitation: Christmas, the day before Christmas,
350 the day after Christmas, Thanksgiving, the day before Thanksgiving
351 and the day after Thanksgiving.
352 (b) All state-owned intermediate care facilities
353 for the mentally retarded shall be reimbursed on a full reasonable
354 cost basis.
355 (13) Family planning services, including drugs,
356 supplies and devices, when such services are under the supervision
357 of a physician.
358 (14) Clinic services. Such diagnostic, preventive,
359 therapeutic, rehabilitative or palliative services furnished to an
360 outpatient by or under the supervision of a physician or dentist
361 in a facility which is not a part of a hospital but which is
362 organized and operated to provide medical care to outpatients.
363 Clinic services shall include any services reimbursed as
364 outpatient hospital services which may be rendered in such a
365 facility, including those that become so after July 1, 1991. On
366 July 1, 1999, all fees for physicians' services reimbursed under
367 authority of this paragraph (14) shall be reimbursed at ninety
368 percent (90%) of the rate established on January 1, 1999, and as
369 adjusted each January thereafter, under Medicare (Title XVIII of
370 the Social Security Act, as amended), and which shall in no event
371 be less than seventy percent (70%) of the rate established on
372 January 1, 1994. All fees for physicians' services that are
373 covered by both Medicare and Medicaid shall be reimbursed at ten
374 percent (10%) of the adjusted Medicare payment established on
375 January 1, 1999, and as adjusted each January thereafter, under
376 Medicare (Title XVIII of the Social Security Act, as amended), and
377 which shall in no event be less than seventy percent (70%) of the
378 adjusted Medicare payment established on January 1, 1994. On July

379 1, 1999, all fees for dentists' services reimbursed under
380 authority of this paragraph (14) shall be increased to one hundred
381 sixty percent (160%) of the amount of the reimbursement rate that
382 was in effect on June 30, 1999.
383 (15) Home- and community-based services, as provided
384 under Title XIX of the federal Social Security Act, as amended,
385 under waivers, subject to the availability of funds specifically
386 appropriated therefor by the Legislature. Payment for such
387 services shall be limited to individuals who would be eligible for
388 and would otherwise require the level of care provided in a
389 nursing facility. The home- and community-based services
390 authorized under this paragraph shall be expanded over a five-year
391 period beginning July 1, 1999. The division shall certify case
392 management agencies to provide case management services and
393 provide for home- and community-based services for eligible
394 individuals under this paragraph. The home- and community-based
395 services under this paragraph and the activities performed by
396 certified case management agencies under this paragraph shall be
397 funded using state funds that are provided from the appropriation
398 to the Division of Medicaid and used to match federal funds.
399 (16) Mental health services. Approved therapeutic and
400 case management services provided by (a) an approved regional
401 mental health/retardation center established under Sections
402 41-19-31 through 41-19-39, or by another community mental health
403 service provider meeting the requirements of the Department of
404 Mental Health to be an approved mental health/retardation center
405 if determined necessary by the Department of Mental Health, using
406 state funds which are provided from the appropriation to the State
407 Department of Mental Health and used to match federal funds under
408 a cooperative agreement between the division and the department,
409 or (b) a facility which is certified by the State Department of
410 Mental Health to provide therapeutic and case management services,
411 to be reimbursed on a fee for service basis. Any such services

412 provided by a facility described in paragraph (b) must have the
413 prior approval of the division to be reimbursable under this
414 section. After June 30, 1997, mental health services provided by
415 regional mental health/retardation centers established under
416 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
417 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
418 psychiatric residential treatment facilities as defined in Section
419 43-11-1, or by another community mental health service provider
420 meeting the requirements of the Department of Mental Health to be
421 an approved mental health/retardation center if determined
422 necessary by the Department of Mental Health, shall not be
423 included in or provided under any capitated managed care pilot
424 program provided for under paragraph (24) of this section.

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

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

444 (b) The division shall establish a Medicare Upper
445 Payment Limits Program as defined in Section 1902 (a) (30) of the
446 federal Social Security Act and any applicable federal
447 regulations. The division shall assess each hospital for the sole
448 purpose of financing the state portion of the Medicare Upper
449 Payment Limits Program. This assessment shall be based on
450 Medicaid utilization, or other appropriate method consistent with
451 federal regulations, and will remain in effect as long as the
452 state participates in the Medicare Upper Payment Limits Program.
453 The division shall make additional reimbursement to hospitals for
454 the Medicare Upper Payment Limits as defined in Section 1902 (a)
455 (30) of the federal Social Security Act and any applicable federal
456 regulations. This paragraph (b) shall stand repealed from and
457 after July 1, 2005.
458 (c) The division shall contract with the
459 Mississippi Hospital Association to provide administrative support
460 for the operation of the disproportionate share hospital program
461 and the Medicare Upper Payment Limits Program. This paragraph (c)
462 shall stand repealed from and after July 1, 2005.
463 (19) (a) Perinatal risk management services. The
464 division shall promulgate regulations to be effective from and
465 after October 1, 1988, to establish a comprehensive perinatal
466 system for risk assessment of all pregnant and infant Medicaid
467 recipients and for management, education and follow-up for those
468 who are determined to be at risk. Services to be performed
469 include case management, nutrition assessment/counseling,
470 psychosocial assessment/counseling and health education. The
471 division shall set reimbursement rates for providers in
472 conjunction with the State Department of Health.
473 (b) Early intervention system services. The
474 division shall cooperate with the State Department of Health,
475 acting as lead agency, in the development and implementation of a
476 statewide system of delivery of early intervention services,

477 pursuant to Part C of the Individuals with Disabilities Education
478 Act (IDEA). The State Department of Health shall certify annually
479 in writing to the director of the division the dollar amount of
480 state early intervention funds available which shall be utilized
481 as a certified match for Medicaid matching funds. Those funds
482 then shall be used to provide expanded targeted case management
483 services for Medicaid eligible children with special needs who are
484 eligible for the state's early intervention system.
485 Qualifications for persons providing service coordination shall be
486 determined by the State Department of Health and the Division of
487 Medicaid.
488 (20) Home- and community-based services for physically
489 disabled approved services as allowed by a waiver from the United
490 States Department of Health and Human Services for home- and
491 community-based services for physically disabled people using
492 state funds which are provided from the appropriation to the State
493 Department of Rehabilitation Services and used to match federal
494 funds under a cooperative agreement between the division and the
495 department, provided that funds for these services are
496 specifically appropriated to the Department of Rehabilitation
497 Services.
498 (21) Nurse practitioner services. Services furnished
499 by a registered nurse who is licensed and certified by the
500 Mississippi Board of Nursing as a nurse practitioner including,
501 but not limited to, nurse anesthetists, nurse midwives, family
502 nurse practitioners, family planning nurse practitioners,
503 pediatric nurse practitioners, obstetrics-gynecology nurse
504 practitioners and neonatal nurse practitioners, under regulations
505 adopted by the division. Reimbursement for such services shall
506 not exceed ninety percent (90%) of the reimbursement rate for
507 comparable services rendered by a physician.
508 (22) Ambulatory services delivered in federally
509 qualified health centers, rural health centers and in clinics of

510 the local health departments of the State Department of Health for
511 individuals eligible for medical assistance under this article
512 based on reasonable costs as determined by the division.
513 (23) Inpatient psychiatric services. Inpatient
514 psychiatric services to be determined by the division for
515 recipients under age twenty-one (21) which are provided under the
516 direction of a physician in an inpatient program in a licensed
517 acute care psychiatric facility or in a licensed psychiatric
518 residential treatment facility, before the recipient reaches age
519 twenty-one (21) or, if the recipient was receiving the services
520 immediately before he reached age twenty-one (21), before the
521 earlier of the date he no longer requires the services or the date
522 he reaches age twenty-two (22), as provided by federal
523 regulations. Precertification of inpatient days and residential
524 treatment days must be obtained as required by the division.
525 (24) Managed care services in a program to be developed
526 by the division by a public or private provider. If managed care
527 services are provided by the division to Medicaid recipients, and
528 those managed care services are operated, managed and controlled
529 by and under the authority of the division, the division shall be
530 responsible for educating the Medicaid recipients who are
531 participants in the managed care program regarding the manner in
532 which the participants should seek health care under the program.
533 Notwithstanding any other provision in this article to the
534 contrary, the division shall establish rates of reimbursement to
535 providers rendering care and services authorized under this
536 paragraph (24), and may revise such rates of reimbursement without
537 amendment to this section by the Legislature for the purpose of
538 achieving effective and accessible health services, and for
539 responsible containment of costs.
540 (25) Birthing center services.
541 (26) Hospice care. As used in this paragraph, the term
542 "hospice care" means a coordinated program of active professional

543 medical attention within the home and outpatient and inpatient
544 care which treats the terminally ill patient and family as a unit,
545 employing a medically directed interdisciplinary team. The
546 program provides relief of severe pain or other physical symptoms
547 and supportive care to meet the special needs arising out of
548 physical, psychological, spiritual, social and economic stresses
549 which are experienced during the final stages of illness and
550 during dying and bereavement and meets the Medicare requirements
551 for participation as a hospice as provided in federal regulations.
552 (27) Group health plan premiums and cost sharing if it
553 is cost effective as defined by the Secretary of Health and Human
554 Services.
555 (28) Other health insurance premiums which are cost
556 effective as defined by the Secretary of Health and Human
557 Services. Medicare eligible must have Medicare Part B before
558 other insurance premiums can be paid.
559 (29) The Division of Medicaid may apply for a waiver
560 from the Department of Health and Human Services for home- and
561 community-based services for developmentally disabled people using
562 state funds which are provided from the appropriation to the State
563 Department of Mental Health and used to match federal funds under
564 a cooperative agreement between the division and the department,
565 provided that funds for these services are specifically
566 appropriated to the Department of Mental Health.
567 (30) Pediatric skilled nursing services for eligible
568 persons under twenty-one (21) years of age.
569 (31) Targeted case management services for children
570 with special needs, under waivers from the United States
571 Department of Health and Human Services, using state funds that
572 are provided from the appropriation to the Mississippi Department
573 of Human Services and used to match federal funds under a
574 cooperative agreement between the division and the department.

575 (32) Care and services provided in Christian Science
576 Sanatoria operated by or listed and certified by The First Church
577 of Christ Scientist, Boston, Massachusetts, rendered in connection
578 with treatment by prayer or spiritual means to the extent that
579 such services are subject to reimbursement under Section 1903 of
580 the Social Security Act.
581 (33) Podiatrist services.
582 (34) The division shall make application to the United
583 States Health Care Financing Administration for a waiver to
584 develop a program of services to personal care and assisted living
585 homes in Mississippi. This waiver shall be completed by December
586 1, 1999.
587 (35) Services and activities authorized in Sections
588 43-27-101 and 43-27-103, using state funds that are provided from
589 the appropriation to the State Department of Human Services and
590 used to match federal funds under a cooperative agreement between
591 the division and the department.
592 (36) Nonemergency transportation services for
593 Medicaid-eligible persons, to be provided by the Division of
594 Medicaid. The division may contract with additional entities to
595 administer nonemergency transportation services as it deems
596 necessary. All providers shall have a valid driver's license,
597 vehicle inspection sticker, valid vehicle license tags and a
598 standard liability insurance policy covering the vehicle.
599 (37) [Deleted]
600 (38) Chiropractic services: a chiropractor's manual
601 manipulation of the spine to correct a subluxation, if x-ray
602 demonstrates that a subluxation exists and if the subluxation has
603 resulted in a neuromusculoskeletal condition for which
604 manipulation is appropriate treatment, and related spinal x-rays
605 performed to document these conditions. Reimbursement for
606 chiropractic services shall not exceed Seven Hundred Dollars
607 ($700.00) per year per beneficiary.

608 (39) Dually eligible Medicare/Medicaid beneficiaries.
609 The division shall pay the Medicare deductible and ten percent
610 (10%) coinsurance amounts for services available under Medicare
611 for the duration and scope of services otherwise available under
612 the Medicaid program.

613 (40) [Deleted]

614 (41) Services provided by the State Department of
615 Rehabilitation Services for the care and rehabilitation of persons
616 with spinal cord injuries or traumatic brain injuries, as allowed
617 under waivers from the United States Department of Health and
618 Human Services, using up to seventy-five percent (75%) of the
619 funds that are appropriated to the Department of Rehabilitation
620 Services from the Spinal Cord and Head Injury Trust Fund
621 established under Section 37-33-261 and used to match federal
622 funds under a cooperative agreement between the division and the
623 department.

624 (42) Notwithstanding any other provision in this
625 article to the contrary, the division is hereby authorized to
626 develop a population health management program for women and
627 children health services through the age of two (2). This program
628 is primarily for obstetrical care associated with low birth weight
629 and pre-term babies. In order to effect cost savings, the
630 division may develop a revised payment methodology which may
631 include at-risk capitated payments.

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

637 (44) Nursing facility services for the severely
638 disabled.

639 (a) Severe disabilities include, but are not
640 limited to, spinal cord injuries, closed head injuries and
641 ventilator dependent patients.
642 (b) Those services must be provided in a long-term
643 care nursing facility dedicated to the care and treatment of
644 persons with severe disabilities, and shall be reimbursed as a
645 separate category of nursing facilities.
646 (45) Physician assistant services. Services furnished
647 by a physician assistant who is licensed by the State Board of
648 Medical Licensure and is practicing with physician supervision
649 under regulations adopted by the board, under regulations adopted
650 by the division. Reimbursement for those services shall not
651 exceed ninety percent (90%) of the reimbursement rate for
652 comparable services rendered by a physician.
653 (46) The division shall make application to the federal
654 Health Care Financing Administration for a waiver to develop and
655 provide services for children with serious emotional disturbances
656 as defined in Section 43-14-1(1), which may include home- and
657 community-based services, case management services or managed care
658 services through mental health providers certified by the
659 Department of Mental Health. The division may implement and
660 provide services under this waivered program only if funds for
661 these services are specifically appropriated for this purpose by
662 the Legislature, or if funds are voluntarily provided by affected
663 agencies.
664 (47) Notwithstanding any other provision in this
665 article to the contrary, the division is hereby authorized to
666 develop and implement disease management programs, including the
667 use of grants, waivers, demonstrations or other projects as
668 necessary.
669 Notwithstanding any provision of this article, except as
670 authorized in the following paragraph and in Section 43-13-139,
671 neither (a) the limitations on quantity or frequency of use of or

672 the fees or charges for any of the care or services available to
673 recipients under this section, nor (b) the payments or rates of
674 reimbursement to providers rendering care or services authorized
675 under this section to recipients, may be increased, decreased or
676 otherwise changed from the levels in effect on July 1, 1999,
677 unless such is authorized by an amendment to this section by the
678 Legislature. However, the restriction in this paragraph shall not
679 prevent the division from changing the payments or rates of
680 reimbursement to providers without an amendment to this section
681 whenever such changes are required by federal law or regulation,
682 or whenever such changes are necessary to correct administrative
683 errors or omissions in calculating such payments or rates of
684 reimbursement.

685 Notwithstanding any provision of this article, no new groups
686 or categories of recipients and new types of care and services may
687 be added without enabling legislation from the Mississippi
688 Legislature, except that the division may authorize such changes
689 without enabling legislation when such addition of recipients or
690 services is ordered by a court of proper authority. The director
691 shall keep the Governor advised on a timely basis of the funds
692 available for expenditure and the projected expenditures. In the
693 event current or projected expenditures can be reasonably
694 anticipated to exceed the amounts appropriated for any fiscal
695 year, the Governor, after consultation with the director, shall
696 discontinue any or all of the payment of the types of care and
697 services as provided herein which are deemed to be optional
698 services under Title XIX of the federal Social Security Act, as
699 amended, for any period necessary to not exceed appropriated
700 funds, and when necessary shall institute any other cost
701 containment measures on any program or programs authorized under
702 the article to the extent allowed under the federal law governing
703 such program or programs, it being the intent of the Legislature

704 that expenditures during any fiscal year shall not exceed the
705 amounts appropriated for such fiscal year.

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

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

719 43-13-121. (1) The division is authorized and empowered to
720 administer a program of medical assistance under the provisions of
721 this article, and to do the following:

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

725 (i) Establishing methods and procedures as may be
726 necessary for the proper and efficient administration of this
727 article;

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

731 (iii) Establishing reasonable fees, charges and
732 rates for medical services and drugs; and in doing so shall fix
733 all such fees, charges and rates at the minimum levels absolutely
734 necessary to provide the medical assistance authorized by this
735 article, and shall not change any such fees, charges or rates
736 except as may be authorized in Section 43-13-117;

737 (iv) Providing for fair and impartial hearings;
738 (v) Providing safeguards for preserving the
739 confidentiality of records; and
740 (vi) For detecting and processing fraudulent
741 practices and abuses of the program;
742 (b) Receive and expend state, federal and other funds
743 in accordance with court judgments or settlements and agreements
744 between the State of Mississippi and the federal government, the
745 rules and regulations promulgated by the division, with the
746 approval of the Governor, and within the limitations and
747 restrictions of this article and within the limits of funds
748 available for such purpose;
749 (c) Subject to the limits imposed by this article, to
750 submit a plan for medical assistance to the federal Department of
751 Health and Human Services for approval pursuant to the provisions
752 of the Social Security Act, to act for the state in making
753 negotiations relative to the submission and approval of such plan,
754 to make such arrangements, not inconsistent with the law, as may
755 be required by or pursuant to federal law to obtain and retain
756 such approval and to secure for the state the benefits of the
757 provisions of such law;
758 No agreements, specifically including the general plan for
759 the operation of the Medicaid program in this state, shall be made
760 by and between the division and the Department of Health and Human
761 Services unless the Attorney General of the State of Mississippi
762 has reviewed the agreements, specifically including the
763 operational plan, and has certified in writing to the Governor and
764 to the director of the division that the agreements, including the
765 plan of operation, have been drawn strictly in accordance with the
766 terms and requirements of this article;
767 (d) Pursuant to the purposes and intent of this article
768 and in compliance with its provisions, provide for aged persons
769 otherwise eligible for the benefits provided under Title XVIII of

770 the federal Social Security Act by expenditure of funds available
771 for such purposes;
772 (e) To make reports to the federal Department of Health
773 and Human Services as from time to time may be required by such
774 federal department and to the Mississippi Legislature as
775 hereinafter provided;
776 (f) Define and determine the scope, duration and amount
777 of medical assistance which may be provided in accordance with
778 this article and establish priorities therefor in conformity with
779 this article;
780 (g) Cooperate and contract with other state agencies
781 for the purpose of coordinating medical assistance rendered under
782 this article and eliminating duplication and inefficiency in the
783 program;
784 (h) Adopt and use an official seal of the division;
785 (i) Sue in its own name on behalf of the State of
786 Mississippi and employ legal counsel on a contingency basis with
787 the approval of the Attorney General;
788 (j) To recover any and all payments incorrectly made by
789 the division or by the Medicaid Commission to a recipient or
790 provider from the recipient or provider receiving the payments;
791 (k) To recover any and all payments by the division or
792 by the Medicaid Commission fraudulently obtained by a recipient or
793 provider. Additionally, if recovery of any payments fraudulently
794 obtained by a recipient or provider is made in any court, then,
795 upon motion of the Governor, the judge of the court may award
796 twice the payments recovered as damages;
797 (l) Have full, complete and plenary power and authority
798 to conduct such investigations as it may deem necessary and
799 requisite of alleged or suspected violations or abuses of the
800 provisions of this article or of the regulations adopted hereunder
801 including, but not limited to, fraudulent or unlawful act or deed
802 by applicants for medical assistance or other benefits, or

803 payments made to any person, firm or corporation under the terms,
804 conditions and authority of this article, to suspend or disqualify
805 any provider of services, applicant or recipient for gross abuse,
806 fraudulent or unlawful acts for such periods, including
807 permanently, and under such conditions as the division may deem
808 proper and just, including the imposition of a legal rate of
809 interest on the amount improperly or incorrectly paid. Recipients
810 who are found to have misused or abused medical assistance
811 benefits may be locked into one (1) physician and/or one (1)
812 pharmacy of the recipient's choice for a reasonable amount of time
813 in order to educate and promote appropriate use of medical
814 services, in accordance with federal regulations. Should an
815 administrative hearing become necessary, the division shall be
816 authorized, should the provider not succeed in his defense, in
817 taxing the costs of the administrative hearing, including the
818 costs of the court reporter or stenographer and transcript, to the
819 provider. The convictions of a recipient or a provider in a state
820 or federal court for abuse, fraudulent or unlawful acts under this
821 chapter shall constitute an automatic disqualification of the
822 recipient or automatic disqualification of the provider from
823 participation under the Medicaid program.

824 A conviction, for the purposes of this chapter, shall include
825 a judgment entered on a plea of nolo contendere or a
826 nonadjudicated guilty plea and shall have the same force as a
827 judgment entered pursuant to a guilty plea or a conviction
828 following trial. A certified copy of the judgment of the court of
829 competent jurisdiction of such conviction shall constitute prima
830 facie evidence of such conviction for disqualification purposes;

831 (m) Establish and provide such methods of
832 administration as may be necessary for the proper and efficient
833 operation of the program, fully utilizing computer equipment as
834 may be necessary to oversee and control all current expenditures
835 for purposes of this article, and to closely monitor and supervise

836 all recipient payments and vendors rendering such services
837 hereunder;

838 (n) To cooperate and contract with the federal
839 government for the purpose of providing medical assistance to
840 Vietnamese and Cambodian refugees, pursuant to the provisions of
841 Public Law 94-23 and Public Law 94-24, including any amendments
842 thereto, only to the extent that such assistance and the
843 administrative cost related thereto are one hundred percent (100%)
844 reimbursable by the federal government. For the purposes of
845 Section 43-13-117, persons receiving medical assistance pursuant
846 to Public Law 94-23 and Public Law 94-24, including any amendments
847 thereto, shall not be considered a new group or category of
848 recipient; and

849 (o) The division shall impose penalties upon Medicaid
850 only, Title XIX participating long-term care facilities found to
851 be in noncompliance with division and certification standards in
852 accordance with federal and state regulations, including interest
853 at the same rate calculated by the Department of Health and Human
854 Services and/or the Health Care Financing Administration under
855 federal regulations.

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

859 (3) The division, and the State Department of Health as the
860 agency for licensure of health care facilities and certification
861 and inspection for the Medicaid and/or Medicare programs, shall
862 contract for or otherwise provide for the consolidation of on-site
863 inspections of health care facilities which are necessitated by
864 the respective programs and functions of the division and the
865 department.

866 (4) The division and its hearing officers shall have power
867 to preserve and enforce order during hearings; to issue subpoenas
868 for, to administer oaths to and to compel the attendance and

869 testimony of witnesses, or the production of books, papers,
870 documents and other evidence, or the taking of depositions before
871 any designated individual competent to administer oaths; to
872 examine witnesses; and to do all things conformable to law which
873 may be necessary to enable them effectively to discharge the
874 duties of their office. In compelling the attendance and
875 testimony of witnesses, or the production of books, papers,
876 documents and other evidence, or the taking of depositions, as
877 authorized by this section, the division or its hearing officers
878 may designate an individual employed by the division or some other
879 suitable person to execute and return such process, whose action
880 in executing and returning such process shall be as lawful as if
881 done by the sheriff or some other proper officer authorized to
882 execute and return process in the county where the witness may
883 reside. In carrying out the investigatory powers under the
884 provisions of this article, the director or other designated
885 person or persons shall be authorized to examine, obtain, copy or
886 reproduce the books, papers, documents, medical charts,
887 prescriptions and other records relating to medical care and
888 services furnished by the provider to a recipient or designated
889 recipients of Medicaid services under investigation. In the
890 absence of the voluntary submission of the books, papers,
891 documents, medical charts, prescriptions and other records, the
892 Governor, the director, or other designated person shall be
893 authorized to issue and serve subpoenas instantly upon such
894 provider, his agent, servant or employee for the production of the
895 books, papers, documents, medical charts, prescriptions or other
896 records during an audit or investigation of the provider. If any
897 provider or his agent, servant or employee should refuse to
898 produce the records after being duly subpoenaed, the director
899 shall be authorized to certify such facts and institute contempt
900 proceedings in the manner, time, and place as authorized by law
901 for administrative proceedings. As an additional remedy, the

902 division shall be authorized to recover all amounts paid to the
903 provider covering the period of the audit or investigation,
904 inclusive of a legal rate of interest and a reasonable attorney's
905 fee and costs of court if suit becomes necessary. Division staff
906 shall have immediate access to the provider's physical location,
907 facilities, records, documents, books, and any other records
908 relating to medical care and services rendered to recipients
909 during regular business hours.

910 (5) If any person in proceedings before the division
911 disobeys or resists any lawful order or process, or misbehaves
912 during a hearing or so near the place thereof as to obstruct the
913 same, or neglects to produce, after having been ordered to do so,
914 any pertinent book, paper or document, or refuses to appear after
915 having been subpoenaed, or upon appearing refuses to take the oath
916 as a witness, or after having taken the oath refuses to be
917 examined according to law, the director shall certify the facts to
918 any court having jurisdiction in the place in which it is sitting,
919 and the court shall thereupon, in a summary manner, hear the
920 evidence as to the acts complained of, and if the evidence so
921 warrants, punish such person in the same manner and to the same
922 extent as for a contempt committed before the court, or commit
923 such person upon the same condition as if the doing of the
924 forbidden act had occurred with reference to the process of, or in
925 the presence of, the court.

926 (6) In suspending or terminating any provider from
927 participation in the Medicaid program, the division shall preclude
928 such provider from submitting claims for payment, either
929 personally or through any clinic, group, corporation or other
930 association to the division or its fiscal agents for any services
931 or supplies provided under the Medicaid program except for those
932 services or supplies provided prior to the suspension or
933 termination. No clinic, group, corporation or other association
934 which is a provider of services shall submit claims for payment to

935 the division or its fiscal agents for any services or supplies
936 provided by a person within such organization who has been
937 suspended or terminated from participation in the Medicaid program
938 except for those services or supplies provided prior to the
939 suspension or termination. When this provision is violated by a
940 provider of services which is a clinic, group, corporation or
941 other association, the division may suspend or terminate such
942 organization from participation. Suspension may be applied by the
943 division to all known affiliates of a provider, provided that each
944 decision to include an affiliate is made on a case-by-case basis
945 after giving due regard to all relevant facts and circumstances.
946 The violation, failure, or inadequacy of performance may be
947 imputed to a person with whom the provider is affiliated where
948 such conduct was accomplished with the course of his official duty
949 or was effectuated by him with the knowledge or approval of such
950 person.

951 (7) The division may deny or revoke enrollment in the
952 Medicaid program to a provider if any of the following are found
953 to be applicable to the provider, his agent, a managing employee,
954 or any person having an ownership interest equal to five percent
955 (5%) or greater in the provider:

956 (a) Failure to truthfully or fully disclose any and all
957 information required, or the concealment of any and all
958 information required, on a claim, a provider application or a
959 provider agreement or the making of a false or misleading
960 statement to the division relative to the Medicaid program.

961 (b) Previous or current exclusion, suspension,
962 termination from or the involuntary withdrawing from participation
963 in, the Medicaid program, any other state's Medicaid program,
964 Medicare or any other public or private health or health insurance
965 program. If the division ascertains that a provider has been
966 convicted of a felony under federal or state law for an offense
967 which the division determines is detrimental to the best interest

968 of the program or of Medicaid beneficiaries, the division may
969 refuse to enter into an agreement with such provider, or may
970 terminate or refuse to renew an existing agreement.
971 (c) Conviction under federal or state law of a criminal
972 offense relating to the delivery of any goods, services or
973 supplies, including the performance of management or
974 administrative services relating to the delivery of the goods,
975 services or supplies, under the Medicaid program, any other
976 state's Medicaid program, Medicare or any other public or private
977 health or health insurance program.
978 (d) Conviction under federal or state law of a criminal
979 offense relating to the neglect or abuse of a patient in
980 connection with the delivery of any goods, services or supplies.
981 (e) Conviction under federal or state law of a criminal
982 offense relating to the unlawful manufacture, distribution,
983 prescription, or dispensing of a controlled substance.
984 (f) Conviction under federal or state law of a criminal
985 offense relating to fraud, theft, embezzlement, breach of
986 fiduciary responsibility or other financial misconduct.
987 (g) Conviction under federal or state law of a criminal
988 offense punishable by imprisonment of a year or more which
989 involves moral turpitude, or acts against the elderly, children or
990 infirm.
991 (h) Conviction under federal or state law of a criminal
992 offense in connection with the interference or obstruction of any
993 investigation into any criminal offense listed in paragraphs (c)
994 through (i) of this subsection.
995 (i) Sanction pursuant to a violation of federal or
996 state laws or rules relative to the Medicaid program, any other
997 state's Medicaid program, Medicare or any other public health care
998 or health insurance program.
999 (j) Violation of licensing or certification conditions
1000 or professional standards relating to the licenses or

1001 certification of providers or the required quality of goods,
1002 services or supplies provided.

1003 (k) Failure to pay recovery properly assessed or
1004 pursuant to an approved repayment schedule under the Medicaid
1005 program.

1006 (l) Failure to meet any condition of enrollment.

1007 **SECTION 3.** Section 43-13-123, Mississippi Code of 1972, is
1008 amended as follows:

1009 43-13-123. The determination of the method of providing
1010 payment of claims under this article shall be made by the
1011 division, with approval of the Governor, which methods may be:

1012 (1) By contract with insurance companies licensed to do
1013 business in the State of Mississippi or with nonprofit hospital
1014 service corporations, medical or dental service corporations,
1015 authorized to do business in Mississippi to underwrite on an
1016 insured premium approach, such medical assistance benefits as may
1017 be available, and any carrier selected pursuant to the provisions
1018 of this article is hereby expressly authorized and empowered to
1019 undertake the performance of the requirements of such contract.

1020 (2) By contract with an insurance company licensed to
1021 do business in the State of Mississippi or with nonprofit hospital
1022 service, medical or dental service organizations, or other
1023 organizations including data processing companies, authorized to
1024 do business in Mississippi to act as fiscal agent.

1025 The division shall obtain services to be provided under
1026 either of the above-described provisions pursuant to the Personal
1027 Service Contract Review Board Procurement Regulations. *** * ***

1028 The authorization of the foregoing methods shall not preclude
1029 other methods of providing payment of claims through direct
1030 operation of the program by the state or its agencies.

1031 **SECTION 4.** Section 43-13-145, Mississippi Code of 1972, is
1032 amended as follows:

1033 43-13-145. (1) Upon each nursing facility licensed or
1034 certified by the State of Mississippi and each intermediate care
1035 facility for the mentally retarded licensed by the State of
1036 Mississippi, there is levied an assessment in an amount set by the
1037 division not exceeding Two Dollars ($2.00) per day, or fraction
1038 thereof, for each * * * licensed or certified bed of the facility.
1039 The division may apply for a waiver from the U.S. Secretary of
1040 Health and Human Services to exempt nonprofit, public, charitable
1041 or religious facilities from the assessment levied under this
1042 subsection, and if a waiver is granted, such facilities shall be
1043 exempt from any assessment levied under this subsection after the
1044 date that the division receives notice that the waiver has been
1045 granted.
1046 (2) The assessment levied under this section shall be
1047 collected by the division each quarter beginning on July 1, 1992,
1048 and shall be based on data for the quarter ending three (3) months
1049 before the date the assessments are to be collected.
1050 (3) All assessments collected under this section shall be
1051 deposited in the Medical Care Fund created by Section 43-13-143.
1052 (4) The assessment levied under this section shall be in
1053 addition to any other assessments, taxes or fees levied by law.
1054 (5) The assessment levied under this section shall
1055 constitute a debt due the State of Mississippi from the time the
1056 assessment is due until it is paid. If any facility liable for
1057 payment of such assessment does not pay the assessment when it is
1058 due, the division shall give written notice to the facility
1059 demanding payment of the assessment within ten (10) days from the
1060 date of delivery of the notice. Such notice shall be sent by
1061 certified or registered mail or delivered to the facility by an
1062 agent of the division. If any facility liable for the assessment
1063 fails or refuses to pay it after receiving the notice and demand,
1064 the division may withhold the Medicaid reimbursement payments that

1065 are otherwise scheduled to be made to the facility from the time
1066 the assessment is due until it is paid by the facility.

1067 **SECTION 5.** Section 41-7-191, Mississippi Code of 1972, is
1068 amended as follows:

1069 41-7-191. (1) No person shall engage in any of the
1070 following activities without obtaining the required certificate of
1071 need:

1072 (a) The construction, development or other
1073 establishment of a new health care facility;

1074 (b) The relocation of a health care facility or portion
1075 thereof, or major medical equipment, unless such relocation of a
1076 health care facility or portion thereof, or major medical
1077 equipment, which does not involve a capital expenditure by or on
1078 behalf of a health care facility, is within five thousand two
1079 hundred eighty (5,280) feet from the main entrance of the health
1080 care facility;

1081 (c) A change over a period of two (2) years' time, as
1082 established by the State Department of Health, in existing bed
1083 complement through the addition of more than ten (10) beds or more
1084 than ten percent (10%) of the total bed capacity of a designated
1085 licensed category or subcategory of any health care facility,
1086 whichever is less, from one physical facility or site to another;
1087 the conversion over a period of two (2) years' time, as
1088 established by the State Department of Health, of existing bed
1089 complement of more than ten (10) beds or more than ten percent
1090 (10%) of the total bed capacity of a designated licensed category
1091 or subcategory of any such health care facility, whichever is
1092 less; or the alteration, modernizing or refurbishing of any unit
1093 or department wherein such beds may be located; provided, however,
1094 that from and after July 1, 1994, no health care facility shall be
1095 authorized to add any beds or convert any beds to another category
1096 of beds without a certificate of need under the authority of
1097 subsection (1)(c) of this section unless there is a projected need

1098 for such beds in the planning district in which the facility is
1099 located, as reported in the most current State Health Plan;
1100 (d) Offering of the following health services if those
1101 services have not been provided on a regular basis by the proposed
1102 provider of such services within the period of twelve (12) months
1103 prior to the time such services would be offered:
1104 (i) Open heart surgery services;
1105 (ii) Cardiac catheterization services;
1106 (iii) Comprehensive inpatient rehabilitation
1107 services;
1108 (iv) Licensed psychiatric services;
1109 (v) Licensed chemical dependency services;
1110 (vi) Radiation therapy services;
1111 (vii) Diagnostic imaging services of an invasive
1112 nature, i.e. invasive digital angiography;
1113 (viii) Nursing home care as defined in
1114 subparagraphs (iv), (vi) and (viii) of Section 41-7-173(h);
1115 (ix) Home health services;
1116 (x) Swing-bed services;
1117 (xi) Ambulatory surgical services;
1118 (xii) Magnetic resonance imaging services;
1119 (xiii) Extracorporeal shock wave lithotripsy
1120 services;
1121 (xiv) Long-term care hospital services;
1122 (xv) Positron Emission Tomography (PET) services;
1123 (e) The relocation of one or more health services from
1124 one physical facility or site to another physical facility or
1125 site, unless such relocation, which does not involve a capital
1126 expenditure by or on behalf of a health care facility, (i) is to a
1127 physical facility or site within one thousand three hundred twenty
1128 (1,320) feet from the main entrance of the health care facility
1129 where the health care service is located, or (ii) is the result of
1130 an order of a court of appropriate jurisdiction or a result of

1131 pending litigation in such court, or by order of the State
1132 Department of Health, or by order of any other agency or legal
1133 entity of the state, the federal government, or any political
1134 subdivision of either, whose order is also approved by the State
1135 Department of Health;

1136 (f) The acquisition or otherwise control of any major
1137 medical equipment for the provision of medical services; provided,
1138 however, (i) the acquisition of any major medical equipment used
1139 only for research purposes, and (ii) the acquisition of major
1140 medical equipment to replace medical equipment for which a
1141 facility is already providing medical services and for which the
1142 State Department of Health has been notified before the date of
1143 such acquisition shall be exempt from this paragraph; an
1144 acquisition for less than fair market value must be reviewed, if
1145 the acquisition at fair market value would be subject to review;

1146 (g) Changes of ownership of existing health care
1147 facilities in which a notice of intent is not filed with the State
1148 Department of Health at least thirty (30) days prior to the date
1149 such change of ownership occurs, or a change in services or bed
1150 capacity as prescribed in paragraph (c) or (d) of this subsection
1151 as a result of the change of ownership; an acquisition for less
1152 than fair market value must be reviewed, if the acquisition at
1153 fair market value would be subject to review;

1154 (h) The change of ownership of any health care facility
1155 defined in subparagraphs (iv), (vi) and (viii) of Section
1156 41-7-173(h), in which a notice of intent as described in paragraph
1157 (g) has not been filed and if the Executive Director, Division of
1158 Medicaid, Office of the Governor, has not certified in writing
1159 that there will be no increase in allowable costs to Medicaid from
1160 revaluation of the assets or from increased interest and
1161 depreciation as a result of the proposed change of ownership;

1162 (i) Any activity described in paragraphs (a) through
1163 (h) if undertaken by any person if that same activity would

1164 require certificate of need approval if undertaken by a health
1165 care facility;

1166 (j) Any capital expenditure or deferred capital
1167 expenditure by or on behalf of a health care facility not covered
1168 by paragraphs (a) through (h);

1169 (k) The contracting of a health care facility as
1170 defined in subparagraphs (i) through (viii) of Section 41-7-173(h)
1171 to establish a home office, subunit, or branch office in the space
1172 operated as a health care facility through a formal arrangement
1173 with an existing health care facility as defined in subparagraph
1174 (ix) of Section 41-7-173(h).

1175 (2) The State Department of Health shall not grant approval
1176 for or issue a certificate of need to any person proposing the new
1177 construction of, addition to, or expansion of any health care
1178 facility defined in subparagraphs (iv) (skilled nursing facility)
1179 and (vi) (intermediate care facility) of Section 41-7-173(h) or
1180 the conversion of vacant hospital beds to provide skilled or
1181 intermediate nursing home care, except as hereinafter authorized:

1182 (a) The department may issue a certificate of need to
1183 any person proposing the new construction of any health care
1184 facility defined in subparagraphs (iv) and (vi) of Section
1185 41-7-173(h) as part of a life care retirement facility, in any
1186 county bordering on the Gulf of Mexico in which is located a
1187 National Aeronautics and Space Administration facility, not to
1188 exceed forty (40) beds. From and after July 1, 1999, there shall
1189 be no prohibition or restrictions on participation in the Medicaid
1190 program (Section 43-13-101 et seq.) for the beds in the health
1191 care facility that were authorized under this paragraph (a).

1192 (b) The department may issue certificates of need in
1193 Harrison County to provide skilled nursing home care for
1194 Alzheimer's Disease patients and other patients, not to exceed one
1195 hundred fifty (150) beds. From and after July 1, 1999, there
1196 shall be no prohibition or restrictions on participation in the

1197 Medicaid program (Section 43-13-101 et seq.) for the beds in the
1198 nursing facilities that were authorized under this paragraph (b).
1199 (c) The department may issue a certificate of need for
1200 the addition to or expansion of any skilled nursing facility that
1201 is part of an existing continuing care retirement community
1202 located in Madison County, provided that the recipient of the
1203 certificate of need agrees in writing that the skilled nursing
1204 facility will not at any time participate in the Medicaid program
1205 (Section 43-13-101 et seq.) or admit or keep any patients in the
1206 skilled nursing facility who are participating in the Medicaid
1207 program. This written agreement by the recipient of the
1208 certificate of need shall be fully binding on any subsequent owner
1209 of the skilled nursing facility, if the ownership of the facility
1210 is transferred at any time after the issuance of the certificate
1211 of need. Agreement that the skilled nursing facility will not
1212 participate in the Medicaid program shall be a condition of the
1213 issuance of a certificate of need to any person under this
1214 paragraph (c), and if such skilled nursing facility at any time
1215 after the issuance of the certificate of need, regardless of the
1216 ownership of the facility, participates in the Medicaid program or
1217 admits or keeps any patients in the facility who are participating
1218 in the Medicaid program, the State Department of Health shall
1219 revoke the certificate of need, if it is still outstanding, and
1220 shall deny or revoke the license of the skilled nursing facility,
1221 at the time that the department determines, after a hearing
1222 complying with due process, that the facility has failed to comply
1223 with any of the conditions upon which the certificate of need was
1224 issued, as provided in this paragraph and in the written agreement
1225 by the recipient of the certificate of need. The total number of
1226 beds that may be authorized under the authority of this paragraph
1227 (c) shall not exceed sixty (60) beds.
1228 (d) The State Department of Health may issue a
1229 certificate of need to any hospital located in DeSoto County for

1230 the new construction of a skilled nursing facility, not to exceed
1231 one hundred twenty (120) beds, in DeSoto County. From and after
1232 July 1, 1999, there shall be no prohibition or restrictions on
1233 participation in the Medicaid program (Section 43-13-101 et seq.)
1234 for the beds in the nursing facility that were authorized under
1235 this paragraph (d).
1236 (e) The State Department of Health may issue a
1237 certificate of need for the construction of a nursing facility or
1238 the conversion of beds to nursing facility beds at a personal care
1239 facility for the elderly in Lowndes County that is owned and
1240 operated by a Mississippi nonprofit corporation, not to exceed
1241 sixty (60) beds. From and after July 1, 1999, there shall be no
1242 prohibition or restrictions on participation in the Medicaid
1243 program (Section 43-13-101 et seq.) for the beds in the nursing
1244 facility that were authorized under this paragraph (e).
1245 (f) The State Department of Health may issue a
1246 certificate of need for conversion of a county hospital facility
1247 in Itawamba County to a nursing facility, not to exceed sixty (60)
1248 beds, including any necessary construction, renovation or
1249 expansion. From and after July 1, 1999, there shall be no
1250 prohibition or restrictions on participation in the Medicaid
1251 program (Section 43-13-101 et seq.) for the beds in the nursing
1252 facility that were authorized under this paragraph (f).
1253 (g) The State Department of Health may issue a
1254 certificate of need for the construction or expansion of nursing
1255 facility beds or the conversion of other beds to nursing facility
1256 beds in either Hinds, Madison or Rankin Counties, not to exceed
1257 sixty (60) beds. From and after July 1, 1999, there shall be no
1258 prohibition or restrictions on participation in the Medicaid
1259 program (Section 43-13-101 et seq.) for the beds in the nursing
1260 facility that were authorized under this paragraph (g).
1261 (h) The State Department of Health may issue a
1262 certificate of need for the construction or expansion of nursing

1263 facility beds or the conversion of other beds to nursing facility
1264 beds in either Hancock, Harrison or Jackson Counties, not to
1265 exceed sixty (60) beds. From and after July 1, 1999, there shall
1266 be no prohibition or restrictions on participation in the Medicaid
1267 program (Section 43-13-101 et seq.) for the beds in the facility
1268 that were authorized under this paragraph (h).
1269 (i) The department may issue a certificate of need for
1270 the new construction of a skilled nursing facility in Leake
1271 County, provided that the recipient of the certificate of need
1272 agrees in writing that the skilled nursing facility will not at
1273 any time participate in the Medicaid program (Section 43-13-101 et
1274 seq.) or admit or keep any patients in the skilled nursing
1275 facility who are participating in the Medicaid program. This
1276 written agreement by the recipient of the certificate of need
1277 shall be fully binding on any subsequent owner of the skilled
1278 nursing facility, if the ownership of the facility is transferred
1279 at any time after the issuance of the certificate of need.
1280 Agreement that the skilled nursing facility will not participate
1281 in the Medicaid program shall be a condition of the issuance of a
1282 certificate of need to any person under this paragraph (i), and if
1283 such skilled nursing facility at any time after the issuance of
1284 the certificate of need, regardless of the ownership of the
1285 facility, participates in the Medicaid program or admits or keeps
1286 any patients in the facility who are participating in the Medicaid
1287 program, the State Department of Health shall revoke the
1288 certificate of need, if it is still outstanding, and shall deny or
1289 revoke the license of the skilled nursing facility, at the time
1290 that the department determines, after a hearing complying with due
1291 process, that the facility has failed to comply with any of the
1292 conditions upon which the certificate of need was issued, as
1293 provided in this paragraph and in the written agreement by the
1294 recipient of the certificate of need. The provision of Section
1295 43-7-193(1) regarding substantial compliance of the projection of

1296 need as reported in the current State Health Plan is waived for
1297 the purposes of this paragraph. The total number of nursing
1298 facility beds that may be authorized by any certificate of need
1299 issued under this paragraph (i) shall not exceed sixty (60) beds.
1300 If the skilled nursing facility authorized by the certificate of
1301 need issued under this paragraph is not constructed and fully
1302 operational within eighteen (18) months after July 1, 1994, the
1303 State Department of Health, after a hearing complying with due
1304 process, shall revoke the certificate of need, if it is still
1305 outstanding, and shall not issue a license for the skilled nursing
1306 facility at any time after the expiration of the eighteen-month
1307 period.

1308 (j) The department may issue certificates of need to
1309 allow any existing freestanding long-term care facility in
1310 Tishomingo County and Hancock County that on July 1, 1995, is
1311 licensed with fewer than sixty (60) beds. For the purposes of
1312 this paragraph (j), the provision of Section 41-7-193(1) requiring
1313 substantial compliance with the projection of need as reported in
1314 the current State Health Plan is waived. From and after July 1,
1315 1999, there shall be no prohibition or restrictions on
1316 participation in the Medicaid program (Section 43-13-101 et seq.)
1317 for the beds in the long-term care facilities that were authorized
1318 under this paragraph (j).

1319 (k) The department may issue a certificate of need for
1320 the construction of a nursing facility at a continuing care
1321 retirement community in Lowndes County. The total number of beds
1322 that may be authorized under the authority of this paragraph (k)
1323 shall not exceed sixty (60) beds. From and after July 1, 2001,
1324 the prohibition on the facility participating in the Medicaid
1325 program (Section 43-13-101 et seq.) that was a condition of
1326 issuance of the certificate of need under this paragraph (k) shall
1327 be revised as follows: The nursing facility may participate in
1328 the Medicaid program from and after July 1, 2001, if the owner of

1329 the facility on July 1, 2001, agrees in writing that no more than
1330 thirty (30) of the beds at the facility will be certified for
1331 participation in the Medicaid program, and that no claim will be
1332 submitted for Medicaid reimbursement for more than thirty (30)
1333 patients in the facility in any month or for any patient in the
1334 facility who is in a bed that is not Medicaid-certified. This
1335 written agreement by the owner of the facility shall be a
1336 condition of licensure of the facility, and the agreement shall be
1337 fully binding on any subsequent owner of the facility if the
1338 ownership of the facility is transferred at any time after July 1,
1339 2001. After this written agreement is executed, the Division of
1340 Medicaid and the State Department of Health shall not certify more
1341 than thirty (30) of the beds in the facility for participation in
1342 the Medicaid program. If the facility violates the terms of the
1343 written agreement by admitting or keeping in the facility on a
1344 regular or continuing basis more than thirty (30) patients who are
1345 participating in the Medicaid program, the State Department of
1346 Health shall revoke the license of the facility, at the time that
1347 the department determines, after a hearing complying with due
1348 process, that the facility has violated the written agreement.
1349 (l) Provided that funds are specifically appropriated
1350 therefor by the Legislature, the department may issue a
1351 certificate of need to a rehabilitation hospital in Hinds County
1352 for the construction of a sixty-bed long-term care nursing
1353 facility dedicated to the care and treatment of persons with
1354 severe disabilities including persons with spinal cord and
1355 closed-head injuries and ventilator-dependent patients. The
1356 provision of Section 41-7-193(1) regarding substantial compliance
1357 with projection of need as reported in the current State Health
1358 Plan is hereby waived for the purpose of this paragraph.
1359 (m) The State Department of Health may issue a
1360 certificate of need to a county-owned hospital in the Second
1361 Judicial District of Panola County for the conversion of not more

1362 than seventy-two (72) hospital beds to nursing facility beds,
1363 provided that the recipient of the certificate of need agrees in
1364 writing that none of the beds at the nursing facility will be
1365 certified for participation in the Medicaid program (Section
1366 43-13-101 et seq.), and that no claim will be submitted for
1367 Medicaid reimbursement in the nursing facility in any day or for
1368 any patient in the nursing facility. This written agreement by
1369 the recipient of the certificate of need shall be a condition of
1370 the issuance of the certificate of need under this paragraph, and
1371 the agreement shall be fully binding on any subsequent owner of
1372 the nursing facility if the ownership of the nursing facility is
1373 transferred at any time after the issuance of the certificate of
1374 need. After this written agreement is executed, the Division of
1375 Medicaid and the State Department of Health shall not certify any
1376 of the beds in the nursing facility for participation in the
1377 Medicaid program. If the nursing facility violates the terms of
1378 the written agreement by admitting or keeping in the nursing
1379 facility on a regular or continuing basis any patients who are
1380 participating in the Medicaid program, the State Department of
1381 Health shall revoke the license of the nursing facility, at the
1382 time that the department determines, after a hearing complying
1383 with due process, that the nursing facility has violated the
1384 condition upon which the certificate of need was issued, as
1385 provided in this paragraph and in the written agreement. If the
1386 certificate of need authorized under this paragraph is not issued
1387 within twelve (12) months after July 1, 2001, the department shall
1388 deny the application for the certificate of need and shall not
1389 issue the certificate of need at any time after the twelve-month
1390 period, unless the issuance is contested. If the certificate of
1391 need is issued and substantial construction of the nursing
1392 facility beds has not commenced within eighteen (18) months after
1393 July 1, 2001, the State Department of Health, after a hearing
1394 complying with due process, shall revoke the certificate of need

1395 if it is still outstanding, and the department shall not issue a
1396 license for the nursing facility at any time after the
1397 eighteen-month period. Provided, however, that if the issuance of
1398 the certificate of need is contested, the department shall require
1399 substantial construction of the nursing facility beds within six
1400 (6) months after final adjudication on the issuance of the
1401 certificate of need.
1402 (n) The department may issue a certificate of need for
1403 the new construction, addition or conversion of skilled nursing
1404 facility beds in Madison County, provided that the recipient of
1405 the certificate of need agrees in writing that the skilled nursing
1406 facility will not at any time participate in the Medicaid program
1407 (Section 43-13-101 et seq.) or admit or keep any patients in the
1408 skilled nursing facility who are participating in the Medicaid
1409 program. This written agreement by the recipient of the
1410 certificate of need shall be fully binding on any subsequent owner
1411 of the skilled nursing facility, if the ownership of the facility
1412 is transferred at any time after the issuance of the certificate
1413 of need. Agreement that the skilled nursing facility will not
1414 participate in the Medicaid program shall be a condition of the
1415 issuance of a certificate of need to any person under this
1416 paragraph (n), and if such skilled nursing facility at any time
1417 after the issuance of the certificate of need, regardless of the
1418 ownership of the facility, participates in the Medicaid program or
1419 admits or keeps any patients in the facility who are participating
1420 in the Medicaid program, the State Department of Health shall
1421 revoke the certificate of need, if it is still outstanding, and
1422 shall deny or revoke the license of the skilled nursing facility,
1423 at the time that the department determines, after a hearing
1424 complying with due process, that the facility has failed to comply
1425 with any of the conditions upon which the certificate of need was
1426 issued, as provided in this paragraph and in the written agreement
1427 by the recipient of the certificate of need. The total number of

1428 nursing facility beds that may be authorized by any certificate of
1429 need issued under this paragraph (n) shall not exceed sixty (60)
1430 beds. If the certificate of need authorized under this paragraph
1431 is not issued within twelve (12) months after July 1, 1998, the
1432 department shall deny the application for the certificate of need
1433 and shall not issue the certificate of need at any time after the
1434 twelve-month period, unless the issuance is contested. If the
1435 certificate of need is issued and substantial construction of the
1436 nursing facility beds has not commenced within eighteen (18)
1437 months after the effective date of July 1, 1998, the State
1438 Department of Health, after a hearing complying with due process,
1439 shall revoke the certificate of need if it is still outstanding,
1440 and the department shall not issue a license for the nursing
1441 facility at any time after the eighteen-month period. Provided,
1442 however, that if the issuance of the certificate of need is
1443 contested, the department shall require substantial construction
1444 of the nursing facility beds within six (6) months after final
1445 adjudication on the issuance of the certificate of need.
1446 (o) The department may issue a certificate of need for
1447 the new construction, addition or conversion of skilled nursing
1448 facility beds in Leake County, provided that the recipient of the
1449 certificate of need agrees in writing that the skilled nursing
1450 facility will not at any time participate in the Medicaid program
1451 (Section 43-13-101 et seq.) or admit or keep any patients in the
1452 skilled nursing facility who are participating in the Medicaid
1453 program. This written agreement by the recipient of the
1454 certificate of need shall be fully binding on any subsequent owner
1455 of the skilled nursing facility, if the ownership of the facility
1456 is transferred at any time after the issuance of the certificate
1457 of need. Agreement that the skilled nursing facility will not
1458 participate in the Medicaid program shall be a condition of the
1459 issuance of a certificate of need to any person under this
1460 paragraph (o), and if such skilled nursing facility at any time

1461 after the issuance of the certificate of need, regardless of the
1462 ownership of the facility, participates in the Medicaid program or
1463 admits or keeps any patients in the facility who are participating
1464 in the Medicaid program, the State Department of Health shall
1465 revoke the certificate of need, if it is still outstanding, and
1466 shall deny or revoke the license of the skilled nursing facility,
1467 at the time that the department determines, after a hearing
1468 complying with due process, that the facility has failed to comply
1469 with any of the conditions upon which the certificate of need was
1470 issued, as provided in this paragraph and in the written agreement
1471 by the recipient of the certificate of need. The total number of
1472 nursing facility beds that may be authorized by any certificate of
1473 need issued under this paragraph (o) shall not exceed sixty (60)
1474 beds. If the certificate of need authorized under this paragraph
1475 is not issued within twelve (12) months after July 1, 2001, the
1476 department shall deny the application for the certificate of need
1477 and shall not issue the certificate of need at any time after the
1478 twelve-month period, unless the issuance is contested. If the
1479 certificate of need is issued and substantial construction of the
1480 nursing facility beds has not commenced within eighteen (18)
1481 months after the effective date of July 1, 2001, the State
1482 Department of Health, after a hearing complying with due process,
1483 shall revoke the certificate of need if it is still outstanding,
1484 and the department shall not issue a license for the nursing
1485 facility at any time after the eighteen-month period. Provided,
1486 however, that if the issuance of the certificate of need is
1487 contested, the department shall require substantial construction
1488 of the nursing facility beds within six (6) months after final
1489 adjudication on the issuance of the certificate of need.
1490 (p) The department may issue a certificate of need for
1491 the construction of a municipally-owned nursing facility within
1492 the Town of Belmont in Tishomingo County, not to exceed sixty (60)
1493 beds, provided that the recipient of the certificate of need

1494 agrees in writing that the skilled nursing facility will not at
1495 any time participate in the Medicaid program (Section 43-13-101 et
1496 seq.) or admit or keep any patients in the skilled nursing
1497 facility who are participating in the Medicaid program. This
1498 written agreement by the recipient of the certificate of need
1499 shall be fully binding on any subsequent owner of the skilled
1500 nursing facility, if the ownership of the facility is transferred
1501 at any time after the issuance of the certificate of need.
1502 Agreement that the skilled nursing facility will not participate
1503 in the Medicaid program shall be a condition of the issuance of a
1504 certificate of need to any person under this paragraph (p), and if
1505 such skilled nursing facility at any time after the issuance of
1506 the certificate of need, regardless of the ownership of the
1507 facility, participates in the Medicaid program or admits or keeps
1508 any patients in the facility who are participating in the Medicaid
1509 program, the State Department of Health shall revoke the
1510 certificate of need, if it is still outstanding, and shall deny or
1511 revoke the license of the skilled nursing facility, at the time
1512 that the department determines, after a hearing complying with due
1513 process, that the facility has failed to comply with any of the
1514 conditions upon which the certificate of need was issued, as
1515 provided in this paragraph and in the written agreement by the
1516 recipient of the certificate of need. The provision of Section
1517 43-7-193(1) regarding substantial compliance of the projection of
1518 need as reported in the current State Health Plan is waived for
1519 the purposes of this paragraph. If the certificate of need
1520 authorized under this paragraph is not issued within twelve (12)
1521 months after July 1, 1998, the department shall deny the
1522 application for the certificate of need and shall not issue the
1523 certificate of need at any time after the twelve-month period,
1524 unless the issuance is contested. If the certificate of need is
1525 issued and substantial construction of the nursing facility beds
1526 has not commenced within eighteen (18) months after July 1, 1998,

1527 the State Department of Health, after a hearing complying with due
1528 process, shall revoke the certificate of need if it is still
1529 outstanding, and the department shall not issue a license for the
1530 nursing facility at any time after the eighteen-month period.
1531 Provided, however, that if the issuance of the certificate of need
1532 is contested, the department shall require substantial
1533 construction of the nursing facility beds within six (6) months
1534 after final adjudication on the issuance of the certificate of
1535 need.

1536 (q) (i) Beginning on July 1, 1999, the State
1537 Department of Health shall issue certificates of need during each
1538 of the next four (4) fiscal years for the construction or
1539 expansion of nursing facility beds or the conversion of other beds
1540 to nursing facility beds in each county in the state having a need
1541 for fifty (50) or more additional nursing facility beds, as shown
1542 in the fiscal year 1999 State Health Plan, in the manner provided
1543 in this paragraph (q). The total number of nursing facility beds
1544 that may be authorized by any certificate of need authorized under
1545 this paragraph (q) shall not exceed sixty (60) beds.

1546 (ii) Subject to the provisions of subparagraph
1547 (v), during each of the next four (4) fiscal years, the department
1548 shall issue six (6) certificates of need for new nursing facility
1549 beds, as follows: During fiscal years 2000, 2001 and 2002, one
1550 (1) certificate of need shall be issued for new nursing facility
1551 beds in the county in each of the four (4) Long-Term Care Planning
1552 Districts designated in the fiscal year 1999 State Health Plan
1553 that has the highest need in the district for those beds; and two
1554 (2) certificates of need shall be issued for new nursing facility
1555 beds in the two (2) counties from the state at large that have the
1556 highest need in the state for those beds, when considering the
1557 need on a statewide basis and without regard to the Long-Term Care
1558 Planning Districts in which the counties are located. During
1559 fiscal year 2003, one (1) certificate of need shall be issued for

1560 new nursing facility beds in any county having a need for fifty
1561 (50) or more additional nursing facility beds, as shown in the
1562 fiscal year 1999 State Health Plan, that has not received a
1563 certificate of need under this paragraph (q) during the three (3)
1564 previous fiscal years. During fiscal year 2000, in addition to
1565 the six (6) certificates of need authorized in this subparagraph,
1566 the department also shall issue a certificate of need for new
1567 nursing facility beds in Amite County and a certificate of need
1568 for new nursing facility beds in Carroll County.
1569 (iii) Subject to the provisions of subparagraph
1570 (v), the certificate of need issued under subparagraph (ii) for
1571 nursing facility beds in each Long-Term Care Planning District
1572 during each fiscal year shall first be available for nursing
1573 facility beds in the county in the district having the highest
1574 need for those beds, as shown in the fiscal year 1999 State Health
1575 Plan. If there are no applications for a certificate of need for
1576 nursing facility beds in the county having the highest need for
1577 those beds by the date specified by the department, then the
1578 certificate of need shall be available for nursing facility beds
1579 in other counties in the district in descending order of the need
1580 for those beds, from the county with the second highest need to
1581 the county with the lowest need, until an application is received
1582 for nursing facility beds in an eligible county in the district.
1583 (iv) Subject to the provisions of subparagraph
1584 (v), the certificate of need issued under subparagraph (ii) for
1585 nursing facility beds in the two (2) counties from the state at
1586 large during each fiscal year shall first be available for nursing
1587 facility beds in the two (2) counties that have the highest need
1588 in the state for those beds, as shown in the fiscal year 1999
1589 State Health Plan, when considering the need on a statewide basis
1590 and without regard to the Long-Term Care Planning Districts in
1591 which the counties are located. If there are no applications for
1592 a certificate of need for nursing facility beds in either of the

1593 two (2) counties having the highest need for those beds on a
1594 statewide basis by the date specified by the department, then the
1595 certificate of need shall be available for nursing facility beds
1596 in other counties from the state at large in descending order of
1597 the need for those beds on a statewide basis, from the county with
1598 the second highest need to the county with the lowest need, until
1599 an application is received for nursing facility beds in an
1600 eligible county from the state at large.

1601 (v) If a certificate of need is authorized to be
1602 issued under this paragraph (q) for nursing facility beds in a
1603 county on the basis of the need in the Long-Term Care Planning
1604 District during any fiscal year of the four-year period, a
1605 certificate of need shall not also be available under this
1606 paragraph (q) for additional nursing facility beds in that county
1607 on the basis of the need in the state at large, and that county
1608 shall be excluded in determining which counties have the highest
1609 need for nursing facility beds in the state at large for that
1610 fiscal year. After a certificate of need has been issued under
1611 this paragraph (q) for nursing facility beds in a county during
1612 any fiscal year of the four-year period, a certificate of need
1613 shall not be available again under this paragraph (q) for
1614 additional nursing facility beds in that county during the
1615 four-year period, and that county shall be excluded in determining
1616 which counties have the highest need for nursing facility beds in
1617 succeeding fiscal years.

1618 (vi) If more than one (1) application is made for
1619 a certificate of need for nursing home facility beds available
1620 under this paragraph (q), in Yalobusha, Newton or Tallahatchie
1621 County, and one (1) of the applicants is a county-owned hospital
1622 located in the county where the nursing facility beds are
1623 available, the department shall give priority to the county-owned
1624 hospital in granting the certificate of need if the following
1625 conditions are met:

1626 1. The county-owned hospital fully meets all
1627 applicable criteria and standards required to obtain a certificate
1628 of need for the nursing facility beds; and
1629 2. The county-owned hospital's qualifications
1630 for the certificate of need, as shown in its application and as
1631 determined by the department, are at least equal to the
1632 qualifications of the other applicants for the certificate of
1633 need.
1634 (r) (i) Beginning on July 1, 1999, the State
1635 Department of Health shall issue certificates of need during each
1636 of the next two (2) fiscal years for the construction or expansion
1637 of nursing facility beds or the conversion of other beds to
1638 nursing facility beds in each of the four (4) Long-Term Care
1639 Planning Districts designated in the fiscal year 1999 State Health
1640 Plan, to provide care exclusively to patients with Alzheimer's
1641 disease.
1642 (ii) Not more than twenty (20) beds may be
1643 authorized by any certificate of need issued under this paragraph
1644 (r), and not more than a total of sixty (60) beds may be
1645 authorized in any Long-Term Care Planning District by all
1646 certificates of need issued under this paragraph (r). However,
1647 the total number of beds that may be authorized by all
1648 certificates of need issued under this paragraph (r) during any
1649 fiscal year shall not exceed one hundred twenty (120) beds, and
1650 the total number of beds that may be authorized in any Long-Term
1651 Care Planning District during any fiscal year shall not exceed
1652 forty (40) beds. Of the certificates of need that are issued for
1653 each Long-Term Care Planning District during the next two (2)
1654 fiscal years, at least one (1) shall be issued for beds in the
1655 northern part of the district, at least one (1) shall be issued
1656 for beds in the central part of the district, and at least one (1)
1657 shall be issued for beds in the southern part of the district.

1658 (iii) The State Department of Health, in
1659 consultation with the Department of Mental Health and the Division
1660 of Medicaid, shall develop and prescribe the staffing levels,
1661 space requirements and other standards and requirements that must
1662 be met with regard to the nursing facility beds authorized under
1663 this paragraph (r) to provide care exclusively to patients with
1664 Alzheimer's disease.
1665 (3) The State Department of Health may grant approval for
1666 and issue certificates of need to any person proposing the new
1667 construction of, addition to, conversion of beds of or expansion
1668 of any health care facility defined in subparagraph (x)
1669 (psychiatric residential treatment facility) of Section
1670 41-7-173(h). The total number of beds which may be authorized by
1671 such certificates of need shall not exceed three hundred
1672 thirty-four (334) beds for the entire state.
1673 (a) Of the total number of beds authorized under this
1674 subsection, the department shall issue a certificate of need to a
1675 privately owned psychiatric residential treatment facility in
1676 Simpson County for the conversion of sixteen (16) intermediate
1677 care facility for the mentally retarded (ICF-MR) beds to
1678 psychiatric residential treatment facility beds, provided that
1679 facility agrees in writing that the facility shall give priority
1680 for the use of those sixteen (16) beds to Mississippi residents
1681 who are presently being treated in out-of-state facilities.
1682 (b) Of the total number of beds authorized under this
1683 subsection, the department may issue a certificate or certificates
1684 of need for the construction or expansion of psychiatric
1685 residential treatment facility beds or the conversion of other
1686 beds to psychiatric residential treatment facility beds in Warren
1687 County, not to exceed sixty (60) psychiatric residential treatment
1688 facility beds, provided that the facility agrees in writing that
1689 no more than thirty (30) of the beds at the psychiatric
1690 residential treatment facility will be certified for participation

1691 in the Medicaid program (Section 43-13-101 et seq.) for the use of
1692 any patients other than those who are participating only in the
1693 Medicaid program of another state, and that no claim will be
1694 submitted to the Division of Medicaid for Medicaid reimbursement
1695 for more than thirty (30) patients in the psychiatric residential
1696 treatment facility in any day or for any patient in the
1697 psychiatric residential treatment facility who is in a bed that is
1698 not Medicaid-certified. This written agreement by the recipient
1699 of the certificate of need shall be a condition of the issuance of
1700 the certificate of need under this paragraph, and the agreement
1701 shall be fully binding on any subsequent owner of the psychiatric
1702 residential treatment facility if the ownership of the facility is
1703 transferred at any time after the issuance of the certificate of
1704 need. After this written agreement is executed, the Division of
1705 Medicaid and the State Department of Health shall not certify more
1706 than thirty (30) of the beds in the psychiatric residential
1707 treatment facility for participation in the Medicaid program for
1708 the use of any patients other than those who are participating
1709 only in the Medicaid program of another state. If the psychiatric
1710 residential treatment facility violates the terms of the written
1711 agreement by admitting or keeping in the facility on a regular or
1712 continuing basis more than thirty (30) patients who are
1713 participating in the Mississippi Medicaid program, the State
1714 Department of Health shall revoke the license of the facility, at
1715 the time that the department determines, after a hearing complying
1716 with due process, that the facility has violated the condition
1717 upon which the certificate of need was issued, as provided in this
1718 paragraph and in the written agreement.

1719 If by January 1, 2002, there has been no significant
1720 commencement of construction of the beds authorized under this
1721 paragraph (b), or no significant action taken to convert existing
1722 beds to the beds authorized under this paragraph, then the
1723 certificate of need that was previously issued under this

1724 paragraph shall expire. If the previously issued certificate of
1725 need expires, the department may accept applications for issuance
1726 of another certificate of need for the beds authorized under this
1727 paragraph, and may issue a certificate of need to authorize the
1728 construction, expansion or conversion of the beds authorized under
1729 this paragraph.
1730 (c) Of the total number of beds authorized under this
1731 subsection, the department shall issue a certificate of need to a
1732 hospital currently operating Medicaid-certified acute psychiatric
1733 beds for adolescents in DeSoto County, for the establishment of a
1734 forty-bed psychiatric residential treatment facility in DeSoto
1735 County, provided that the hospital agrees in writing (i) that the
1736 hospital shall give priority for the use of those forty (40) beds
1737 to Mississippi residents who are presently being treated in
1738 out-of-state facilities, and (ii) that no more than fifteen (15)
1739 of the beds at the psychiatric residential treatment facility will
1740 be certified for participation in the Medicaid program (Section
1741 43-13-101 et seq.), and that no claim will be submitted for
1742 Medicaid reimbursement for more than fifteen (15) patients in the
1743 psychiatric residential treatment facility in any day or for any
1744 patient in the psychiatric residential treatment facility who is
1745 in a bed that is not Medicaid-certified. This written agreement
1746 by the recipient of the certificate of need shall be a condition
1747 of the issuance of the certificate of need under this paragraph,
1748 and the agreement shall be fully binding on any subsequent owner
1749 of the psychiatric residential treatment facility if the ownership
1750 of the facility is transferred at any time after the issuance of
1751 the certificate of need. After this written agreement is
1752 executed, the Division of Medicaid and the State Department of
1753 Health shall not certify more than fifteen (15) of the beds in the
1754 psychiatric residential treatment facility for participation in
1755 the Medicaid program. If the psychiatric residential treatment
1756 facility violates the terms of the written agreement by admitting

1757 or keeping in the facility on a regular or continuing basis more
1758 than fifteen (15) patients who are participating in the Medicaid
1759 program, the State Department of Health shall revoke the license
1760 of the facility, at the time that the department determines, after
1761 a hearing complying with due process, that the facility has
1762 violated the condition upon which the certificate of need was
1763 issued, as provided in this paragraph and in the written
1764 agreement.

1765 (d) Of the total number of beds authorized under this
1766 subsection, the department may issue a certificate or certificates
1767 of need for the construction or expansion of psychiatric
1768 residential treatment facility beds or the conversion of other
1769 beds to psychiatric treatment facility beds, not to exceed thirty
1770 (30) psychiatric residential treatment facility beds, in either
1771 Alcorn, Tishomingo, Prentiss, Lee, Itawamba, Monroe, Chickasaw,
1772 Pontotoc, Calhoun, Lafayette, Union, Benton or Tippah Counties.

1773 (e) Of the total number of beds authorized under this
1774 subsection (3) the department shall issue a certificate of need to
1775 a privately owned, nonprofit psychiatric residential treatment
1776 facility in Hinds County for an eight-bed expansion of the
1777 facility, provided that the facility agrees in writing that the
1778 facility shall give priority for the use of those eight (8) beds
1779 to Mississippi residents who are presently being treated in
1780 out-of-state facilities.

1781 (f) The department shall issue a certificate of need to
1782 a one-hundred-thirty-four-bed specialty hospital located on
1783 twenty-nine and forty-four one-hundredths (29.44) commercial acres
1784 at 5900 Highway 39 North in Meridian (Lauderdale County),
1785 Mississippi, for the addition, construction or expansion of
1786 child/adolescent psychiatric residential treatment facility beds
1787 in Lauderdale County. As a condition of issuance of the
1788 certificate of need under this paragraph, the facility shall give
1789 priority in admissions to the child/adolescent psychiatric

1790 residential treatment facility beds authorized under this
1791 paragraph to patients who otherwise would require out-of-state
1792 placement. * * * For purposes of this paragraph, the provisions
1793 of Section 41-7-193(1) requiring substantial compliance with the
1794 projection of need as reported in the current State Health Plan
1795 are waived. The total number of child/adolescent psychiatric
1796 residential treatment facility beds that may be authorized under
1797 the authority of this paragraph shall be sixty (60) beds. There
1798 shall be no prohibition or restrictions on participation in the
1799 Medicaid program (Section 43-13-101 et seq.) for the person
1800 receiving the certificate of need authorized under this paragraph
1801 or for the beds converted pursuant to the authority of that
1802 certificate of need.
1803 (4) (a) From and after July 1, 1993, the department shall
1804 not issue a certificate of need to any person for the new
1805 construction of any hospital, psychiatric hospital or chemical
1806 dependency hospital that will contain any child/adolescent
1807 psychiatric or child/adolescent chemical dependency beds, or for
1808 the conversion of any other health care facility to a hospital,
1809 psychiatric hospital or chemical dependency hospital that will
1810 contain any child/adolescent psychiatric or child/adolescent
1811 chemical dependency beds, or for the addition of any
1812 child/adolescent psychiatric or child/adolescent chemical
1813 dependency beds in any hospital, psychiatric hospital or chemical
1814 dependency hospital, or for the conversion of any beds of another
1815 category in any hospital, psychiatric hospital or chemical
1816 dependency hospital to child/adolescent psychiatric or
1817 child/adolescent chemical dependency beds, except as hereinafter
1818 authorized:
1819 (i) The department may issue certificates of need
1820 to any person for any purpose described in this subsection,
1821 provided that the hospital, psychiatric hospital or chemical
1822 dependency hospital does not participate in the Medicaid program

1823 (Section 43-13-101 et seq.) at the time of the application for the
1824 certificate of need and the owner of the hospital, psychiatric
1825 hospital or chemical dependency hospital agrees in writing that
1826 the hospital, psychiatric hospital or chemical dependency hospital
1827 will not at any time participate in the Medicaid program or admit
1828 or keep any patients who are participating in the Medicaid program
1829 in the hospital, psychiatric hospital or chemical dependency
1830 hospital. This written agreement by the recipient of the
1831 certificate of need shall be fully binding on any subsequent owner
1832 of the hospital, psychiatric hospital or chemical dependency
1833 hospital, if the ownership of the facility is transferred at any
1834 time after the issuance of the certificate of need. Agreement
1835 that the hospital, psychiatric hospital or chemical dependency
1836 hospital will not participate in the Medicaid program shall be a
1837 condition of the issuance of a certificate of need to any person
1838 under this subparagraph (a)(i), and if such hospital, psychiatric
1839 hospital or chemical dependency hospital at any time after the
1840 issuance of the certificate of need, regardless of the ownership
1841 of the facility, participates in the Medicaid program or admits or
1842 keeps any patients in the hospital, psychiatric hospital or
1843 chemical dependency hospital who are participating in the Medicaid
1844 program, the State Department of Health shall revoke the
1845 certificate of need, if it is still outstanding, and shall deny or
1846 revoke the license of the hospital, psychiatric hospital or
1847 chemical dependency hospital, at the time that the department
1848 determines, after a hearing complying with due process, that the
1849 hospital, psychiatric hospital or chemical dependency hospital has
1850 failed to comply with any of the conditions upon which the
1851 certificate of need was issued, as provided in this subparagraph
1852 and in the written agreement by the recipient of the certificate
1853 of need.

1854 (ii) The department may issue a certificate of
1855 need for the conversion of existing beds in a county hospital in

1856 Choctaw County from acute care beds to child/adolescent chemical
1857 dependency beds. For purposes of this subparagraph, the
1858 provisions of Section 41-7-193(1) requiring substantial compliance
1859 with the projection of need as reported in the current State
1860 Health Plan is waived. The total number of beds that may be
1861 authorized under authority of this subparagraph shall not exceed
1862 twenty (20) beds. There shall be no prohibition or restrictions
1863 on participation in the Medicaid program (Section 43-13-101 et
1864 seq.) for the hospital receiving the certificate of need
1865 authorized under this subparagraph (a)(ii) or for the beds
1866 converted pursuant to the authority of that certificate of need.
1867 (iii) The department may issue a certificate or
1868 certificates of need for the construction or expansion of
1869 child/adolescent psychiatric beds or the conversion of other beds
1870 to child/adolescent psychiatric beds in Warren County. For
1871 purposes of this subparagraph, the provisions of Section
1872 41-7-193(1) requiring substantial compliance with the projection
1873 of need as reported in the current State Health Plan are waived.
1874 The total number of beds that may be authorized under the
1875 authority of this subparagraph shall not exceed twenty (20) beds.
1876 There shall be no prohibition or restrictions on participation in
1877 the Medicaid program (Section 43-13-101 et seq.) for the person
1878 receiving the certificate of need authorized under this
1879 subparagraph (a)(iii) or for the beds converted pursuant to the
1880 authority of that certificate of need.
1881 If by January 1, 2002, there has been no significant
1882 commencement of construction of the beds authorized under this
1883 subparagraph (a)(iii), or no significant action taken to convert
1884 existing beds to the beds authorized under this subparagraph, then
1885 the certificate of need that was previously issued under this
1886 subparagraph shall expire. If the previously issued certificate
1887 of need expires, the department may accept applications for
1888 issuance of another certificate of need for the beds authorized

1889 under this subparagraph, and may issue a certificate of need to
1890 authorize the construction, expansion or conversion of the beds
1891 authorized under this subparagraph.

1892 (iv) The department shall issue a certificate of
1893 need to the Region 7 Mental Health/Retardation Commission for the
1894 construction or expansion of child/adolescent psychiatric beds or
1895 the conversion of other beds to child/adolescent psychiatric beds
1896 in any of the counties served by the commission. For purposes of
1897 this subparagraph, the provisions of Section 41-7-193(1) requiring
1898 substantial compliance with the projection of need as reported in
1899 the current State Health Plan is waived. The total number of beds
1900 that may be authorized under the authority of this subparagraph
1901 shall not exceed twenty (20) beds. There shall be no prohibition
1902 or restrictions on participation in the Medicaid program (Section
1903 43-13-101 et seq.) for the person receiving the certificate of
1904 need authorized under this subparagraph (a)(iv) or for the beds
1905 converted pursuant to the authority of that certificate of need.

1906 (v) The department may issue a certificate of need
1907 to any county hospital located in Leflore County for the
1908 construction or expansion of adult psychiatric beds or the
1909 conversion of other beds to adult psychiatric beds, not to exceed
1910 twenty (20) beds, provided that the recipient of the certificate
1911 of need agrees in writing that the adult psychiatric beds will not
1912 at any time be certified for participation in the Medicaid program
1913 and that the hospital will not admit or keep any patients who are
1914 participating in the Medicaid program in any of such adult
1915 psychiatric beds. This written agreement by the recipient of the
1916 certificate of need shall be fully binding on any subsequent owner
1917 of the hospital if the ownership of the hospital is transferred at
1918 any time after the issuance of the certificate of need. Agreement
1919 that the adult psychiatric beds will not be certified for
1920 participation in the Medicaid program shall be a condition of the
1921 issuance of a certificate of need to any person under this

1922 subparagraph (a)(v), and if such hospital at any time after the
1923 issuance of the certificate of need, regardless of the ownership
1924 of the hospital, has any of such adult psychiatric beds certified
1925 for participation in the Medicaid program or admits or keeps any
1926 Medicaid patients in such adult psychiatric beds, the State
1927 Department of Health shall revoke the certificate of need, if it
1928 is still outstanding, and shall deny or revoke the license of the
1929 hospital at the time that the department determines, after a
1930 hearing complying with due process, that the hospital has failed
1931 to comply with any of the conditions upon which the certificate of
1932 need was issued, as provided in this subparagraph and in the
1933 written agreement by the recipient of the certificate of need.

1934 (vi) The department may issue a certificate or
1935 certificates of need for the expansion of child psychiatric beds
1936 or the conversion of other beds to child psychiatric beds at the
1937 University of Mississippi Medical Center. For purposes of this
1938 subparagraph (a)(vi), the provision of Section 41-7-193(1)
1939 requiring substantial compliance with the projection of need as
1940 reported in the current State Health Plan is waived. The total
1941 number of beds that may be authorized under the authority of this
1942 subparagraph (a)(vi) shall not exceed fifteen (15) beds. There
1943 shall be no prohibition or restrictions on participation in the
1944 Medicaid program (Section 43-13-101 et seq.) for the hospital
1945 receiving the certificate of need authorized under this
1946 subparagraph (a)(vi) or for the beds converted pursuant to the
1947 authority of that certificate of need.

1948 (b) From and after July 1, 1990, no hospital,
1949 psychiatric hospital or chemical dependency hospital shall be
1950 authorized to add any child/adolescent psychiatric or
1951 child/adolescent chemical dependency beds or convert any beds of
1952 another category to child/adolescent psychiatric or
1953 child/adolescent chemical dependency beds without a certificate of
1954 need under the authority of subsection (1)(c) of this section.

1955 (5) The department may issue a certificate of need to a
1956 county hospital in Winston County for the conversion of fifteen
1957 (15) acute care beds to geriatric psychiatric care beds.
1958 (6) The State Department of Health shall issue a certificate
1959 of need to a Mississippi corporation qualified to manage a
1960 long-term care hospital as defined in Section 41-7-173(h)(xii) in
1961 Harrison County, not to exceed eighty (80) beds, including any
1962 necessary renovation or construction required for licensure and
1963 certification, provided that the recipient of the certificate of
1964 need agrees in writing that the long-term care hospital will not
1965 at any time participate in the Medicaid program (Section 43-13-101
1966 et seq.) or admit or keep any patients in the long-term care
1967 hospital who are participating in the Medicaid program. This
1968 written agreement by the recipient of the certificate of need
1969 shall be fully binding on any subsequent owner of the long-term
1970 care hospital, if the ownership of the facility is transferred at
1971 any time after the issuance of the certificate of need. Agreement
1972 that the long-term care hospital will not participate in the
1973 Medicaid program shall be a condition of the issuance of a
1974 certificate of need to any person under this subsection (6), and
1975 if such long-term care hospital at any time after the issuance of
1976 the certificate of need, regardless of the ownership of the
1977 facility, participates in the Medicaid program or admits or keeps
1978 any patients in the facility who are participating in the Medicaid
1979 program, the State Department of Health shall revoke the
1980 certificate of need, if it is still outstanding, and shall deny or
1981 revoke the license of the long-term care hospital, at the time
1982 that the department determines, after a hearing complying with due
1983 process, that the facility has failed to comply with any of the
1984 conditions upon which the certificate of need was issued, as
1985 provided in this subsection and in the written agreement by the
1986 recipient of the certificate of need. For purposes of this
1987 subsection, the provision of Section 41-7-193(1) requiring

1988 substantial compliance with the projection of need as reported in
1989 the current State Health Plan is hereby waived.
1990 (7) The State Department of Health may issue a certificate
1991 of need to any hospital in the state to utilize a portion of its
1992 beds for the "swing-bed" concept. Any such hospital must be in
1993 conformance with the federal regulations regarding such swing-bed
1994 concept at the time it submits its application for a certificate
1995 of need to the State Department of Health, except that such
1996 hospital may have more licensed beds or a higher average daily
1997 census (ADC) than the maximum number specified in federal
1998 regulations for participation in the swing-bed program. Any
1999 hospital meeting all federal requirements for participation in the
2000 swing-bed program which receives such certificate of need shall
2001 render services provided under the swing-bed concept to any
2002 patient eligible for Medicare (Title XVIII of the Social Security
2003 Act) who is certified by a physician to be in need of such
2004 services, and no such hospital shall permit any patient who is
2005 eligible for both Medicaid and Medicare or eligible only for
2006 Medicaid to stay in the swing beds of the hospital for more than
2007 thirty (30) days per admission unless the hospital receives prior
2008 approval for such patient from the Division of Medicaid, Office of
2009 the Governor. Any hospital having more licensed beds or a higher
2010 average daily census (ADC) than the maximum number specified in
2011 federal regulations for participation in the swing-bed program
2012 which receives such certificate of need shall develop a procedure
2013 to insure that before a patient is allowed to stay in the swing
2014 beds of the hospital, there are no vacant nursing home beds
2015 available for that patient located within a fifty-mile radius of
2016 the hospital. When any such hospital has a patient staying in the
2017 swing beds of the hospital and the hospital receives notice from a
2018 nursing home located within such radius that there is a vacant bed
2019 available for that patient, the hospital shall transfer the
2020 patient to the nursing home within a reasonable time after receipt

2021 of the notice. Any hospital which is subject to the requirements
2022 of the two (2) preceding sentences of this subsection may be
2023 suspended from participation in the swing-bed program for a
2024 reasonable period of time by the State Department of Health if the
2025 department, after a hearing complying with due process, determines
2026 that the hospital has failed to comply with any of those
2027 requirements.

2028 (8) The Department of Health shall not grant approval for or
2029 issue a certificate of need to any person proposing the new
2030 construction of, addition to or expansion of a health care
2031 facility as defined in subparagraph (viii) of Section 41-7-173(h).

2032 (9) The Department of Health shall not grant approval for or
2033 issue a certificate of need to any person proposing the
2034 establishment of, or expansion of the currently approved territory
2035 of, or the contracting to establish a home office, subunit or
2036 branch office within the space operated as a health care facility
2037 as defined in Section 41-7-173(h)(i) through (viii) by a health
2038 care facility as defined in subparagraph (ix) of Section
2039 41-7-173(h).

2040 (10) Health care facilities owned and/or operated by the
2041 state or its agencies are exempt from the restraints in this
2042 section against issuance of a certificate of need if such addition
2043 or expansion consists of repairing or renovation necessary to
2044 comply with the state licensure law. This exception shall not
2045 apply to the new construction of any building by such state
2046 facility. This exception shall not apply to any health care
2047 facilities owned and/or operated by counties, municipalities,
2048 districts, unincorporated areas, other defined persons, or any
2049 combination thereof.

2050 (11) The new construction, renovation or expansion of or
2051 addition to any health care facility defined in subparagraph (ii)
2052 (psychiatric hospital), subparagraph (iv) (skilled nursing
2053 facility), subparagraph (vi) (intermediate care facility),

2054 subparagraph (viii) (intermediate care facility for the mentally
2055 retarded) and subparagraph (x) (psychiatric residential treatment
2056 facility) of Section 41-7-173(h) which is owned by the State of
2057 Mississippi and under the direction and control of the State
2058 Department of Mental Health, and the addition of new beds or the
2059 conversion of beds from one category to another in any such
2060 defined health care facility which is owned by the State of
2061 Mississippi and under the direction and control of the State
2062 Department of Mental Health, shall not require the issuance of a
2063 certificate of need under Section 41-7-171 et seq.,
2064 notwithstanding any provision in Section 41-7-171 et seq. to the
2065 contrary.

2066 (12) The new construction, renovation or expansion of or
2067 addition to any veterans homes or domiciliaries for eligible
2068 veterans of the State of Mississippi as authorized under Section
2069 35-1-19 shall not require the issuance of a certificate of need,
2070 notwithstanding any provision in Section 41-7-171 et seq. to the
2071 contrary.

2072 (13) The new construction of a nursing facility or nursing
2073 facility beds or the conversion of other beds to nursing facility
2074 beds shall not require the issuance of a certificate of need,
2075 notwithstanding any provision in Section 41-7-171 et seq. to the
2076 contrary, if the conditions of this subsection are met.

2077 (a) Before any construction or conversion may be
2078 undertaken without a certificate of need, the owner of the nursing
2079 facility, in the case of an existing facility, or the applicant to
2080 construct a nursing facility, in the case of new construction,
2081 first must file a written notice of intent and sign a written
2082 agreement with the State Department of Health that the entire
2083 nursing facility will not at any time participate in or have any
2084 beds certified for participation in the Medicaid program (Section
2085 43-13-101 et seq.), will not admit or keep any patients in the
2086 nursing facility who are participating in the Medicaid program,

2087 and will not submit any claim for Medicaid reimbursement for any
2088 patient in the facility. This written agreement by the owner or
2089 applicant shall be a condition of exercising the authority under
2090 this subsection without a certificate of need, and the agreement
2091 shall be fully binding on any subsequent owner of the nursing
2092 facility if the ownership of the facility is transferred at any
2093 time after the agreement is signed. After the written agreement
2094 is signed, the Division of Medicaid and the State Department of
2095 Health shall not certify any beds in the nursing facility for
2096 participation in the Medicaid program. If the nursing facility
2097 violates the terms of the written agreement by participating in
2098 the Medicaid program, having any beds certified for participation
2099 in the Medicaid program, admitting or keeping any patient in the
2100 facility who is participating in the Medicaid program, or
2101 submitting any claim for Medicaid reimbursement for any patient in
2102 the facility, the State Department of Health shall revoke the
2103 license of the nursing facility at the time that the department
2104 determines, after a hearing complying with due process, that the
2105 facility has violated the terms of the written agreement.

2106 (b) For the purposes of this subsection, participation
2107 in the Medicaid program by a nursing facility includes Medicaid
2108 reimbursement of coinsurance and deductibles for recipients who
2109 are qualified Medicare beneficiaries and/or those who are dually
2110 eligible. Any nursing facility exercising the authority under
2111 this subsection may not bill or submit a claim to the Division of
2112 Medicaid for services to qualified Medicare beneficiaries and/or
2113 those who are dually eligible.

2114 (c) The new construction of a nursing facility or
2115 nursing facility beds or the conversion of other beds to nursing
2116 facility beds described in this section must be either a part of a
2117 completely new continuing care retirement community, as described
2118 in the latest edition of the Mississippi State Health Plan, or an
2119 addition to existing personal care and independent living

2120 components, and so that the completed project will be a continuing
2121 care retirement community, containing (i) independent living
2122 accommodations, (ii) personal care beds, and (iii) the nursing
2123 home facility beds. The three (3) components must be located on a
2124 single site and be operated as one (1) inseparable facility. The
2125 nursing facility component must contain a minimum of thirty (30)
2126 beds. Any nursing facility beds authorized by this section will
2127 not be counted against the bed need set forth in the State Health
2128 Plan, as identified in Section 41-7-171, et seq.

2129 This subsection (13) shall stand repealed from and after July
2130 1, 2005.

2131 (14) The State Department of Health shall issue a
2132 certificate of need to any hospital which is currently licensed
2133 for two hundred fifty (250) or more acute care beds and is located
2134 in any general hospital service area not having a comprehensive
2135 cancer center, for the establishment and equipping of such a
2136 center which provides facilities and services for outpatient
2137 radiation oncology therapy, outpatient medical oncology therapy,
2138 and appropriate support services including the provision of
2139 radiation therapy services. The provision of Section 41-7-193(1)
2140 regarding substantial compliance with the projection of need as
2141 reported in the current State Health Plan is waived for the
2142 purpose of this subsection.

2143 (15) The State Department of Health may authorize the
2144 transfer of hospital beds, not to exceed sixty (60) beds, from the
2145 North Panola Community Hospital to the South Panola Community
2146 Hospital. The authorization for the transfer of those beds shall
2147 be exempt from the certificate of need review process.

2148 (16) Nothing in this section or in any other provision of
2149 Section 41-7-171 et seq. shall prevent any nursing facility from
2150 designating an appropriate number of existing beds in the facility
2151 as beds for providing care exclusively to patients with
2152 Alzheimer's disease.

2153 **SECTION 6.** Section 43-11-19, Mississippi Code of 1972, is
2154 amended as follows:

2155 43-11-19. Information received <u>or caused to be maintained or</u>
2156 <u>collected</u> by the licensing agency through filed reports,
2157 inspection, or as otherwise authorized under this chapter, shall
2158 not be disclosed <u>by any person or party</u> except in a proceeding
2159 involving the questions of licensure; however, the licensing
2160 agency may utilize statistical data concerning types of services
2161 and the utilization of those services for institutions for the
2162 aged or infirm in performing the statutory duties imposed upon it
2163 by Section 41-7-171, et seq. and by Section 43-11-21.

2164 **SECTION 7.** Section 41-63-21, Mississippi Code of 1972, is
2165 amended as follows:

2166 41-63-21. The term "accreditation and quality assurance
2167 materials" as used in Sections 41-63-21 through 41-63-29 means and
2168 shall include written reports, records, correspondence and
2169 materials concerning the accreditation or quality assurance of any
2170 hospital, nursing home or other health care facility and any
2171 medical care foundation, health maintenance organization,
2172 preferred provider organization, individual practice association
2173 or similar entity. *** * *** The confidentiality established by
2174 Sections 41-63-21 through 41-63-29 shall apply to accreditation
2175 and quality assurance materials prepared by an employee, advisor
2176 or consultant of any hospital, nursing home or other health care
2177 facility and any medical care foundation, health maintenance
2178 organization, preferred provider organization, individual practice
2179 association or similar entity and to materials provided by an
2180 employee, advisor or consultant of an accreditation, quality
2181 assurance or similar agency or similar body and to any individual
2182 who is an employee, advisor or consultant of a hospital, nursing
2183 home or other health care facility and any medical care
2184 foundation, health maintenance organization, preferred provider
2185 organization, individual practice association or similar entity or

2186 accrediting, quality assurance or similar agency or body. The
2187 confidentiality established by Sections 41-63-21 through 41-63-29
2188 shall apply to reports, records, correspondence and material
2189 concerning accreditation or quality assurance that are prepared by
2190 the State Department of Health except that if the State Department
2191 of Health determines that substantial noncompliance with licensure
2192 standards exists or that deficiencies that represent a threat to
2193 public safety or patient care exist, the department shall prepare
2194 a written summary of the substantial noncompliance or deficiencies
2195 and the health care provider's response to the department's
2196 determination, and the department's written summary and the health
2197 care provider's response thereto shall be considered public
2198 documents.

2199 **SECTION 8.** Section 43-11-13, Mississippi Code of 1972, is
2200 amended as follows:

2201 43-11-13. (1) The licensing agency shall adopt, amend,
2202 promulgate and enforce such rules, regulations and standards,
2203 including classifications, with respect to all institutions for
2204 the aged or infirm to be licensed under this chapter as may be
2205 designed to further the accomplishment of the purpose of this
2206 chapter in promoting adequate care of individuals in such
2207 institutions in the interest of public health, safety and welfare.
2208 Nothing contained in these or any other rules, regulations and
2209 standards promulgated or enforced by the State Board of Health
2210 should be construed as establishing a medical standard of care.
2211 Such rules, regulations and standards shall be adopted and
2212 promulgated by the licensing agency and shall be recorded and
2213 indexed in a book to be maintained by the licensing agency in its
2214 main office in the State of Mississippi, entitled "Rules,
2215 Regulations and Minimum Standards for Institutions for the Aged or
2216 Infirm" and the book shall be open and available to all
2217 institutions for the aged or infirm and the public generally at
2218 all reasonable times. Upon the adoption of such rules,

2219 regulations and standards, the licensing agency shall mail copies
2220 thereof to all such institutions in the state which have filed
2221 with the agency their names and addresses for this purpose, but
2222 the failure to mail the same or the failure of the institutions to
2223 receive the same shall in no way affect the validity thereof. The
2224 rules, regulations and standards may be amended by the licensing
2225 agency, from time to time, as necessary to promote the health,
2226 safety and welfare of persons living in those institutions.
2227 (2) The licensee shall keep posted in a conspicuous place on
2228 the licensed premises all current rules, regulations and minimum
2229 standards applicable to fire protection measures as adopted by the
2230 licensing agency. The licensee shall furnish to the licensing
2231 agency at least once each six (6) months a certificate of approval
2232 and inspection by state or local fire authorities. Failure to
2233 comply with state laws and/or municipal ordinances and current
2234 rules, regulations and minimum standards as adopted by the
2235 licensing agency, relative to fire prevention measures, shall be
2236 prima facie evidence for revocation of license.
2237 (3) The State Board of Health shall promulgate rules and
2238 regulations restricting the storage, quantity and classes of drugs
2239 allowed in personal care homes. Residents requiring
2240 administration of Schedule II Narcotics as defined in the Uniform
2241 Controlled Substances Law may be admitted to a personal care home.
2242 Schedule drugs may only be allowed in a personal care home if they
2243 are administered or stored utilizing proper procedures under the
2244 direct supervision of a licensed physician or nurse.
2245 (4) (a) Notwithstanding any determination by the licensing
2246 agency that skilled nursing services would be appropriate for a
2247 resident of a personal care home, that resident, the resident's
2248 guardian or the legally recognized responsible party for the
2249 resident may consent in writing for the resident to continue to
2250 reside in the personal care home, if approved in writing by a
2251 licensed physician. Provided, however, that no personal care home

2252 shall allow more than two (2) residents, or ten percent (10%) of
2253 the total number of residents in the facility, whichever is
2254 greater, to remain in the personal care home under the provisions
2255 of this subsection (4). This consent shall be deemed to be
2256 appropriately informed consent as described in the regulations
2257 promulgated by the licensing agency. After that written consent
2258 has been obtained, the resident shall have the right to continue
2259 to reside in the personal care home for as long as the resident
2260 meets the other conditions for residing in the personal care home.
2261 A copy of the written consent and the physician's approval shall
2262 be forwarded by the personal care home to the licensing agency.
2263 (b) The State Board of Health shall promulgate rules
2264 and regulations restricting the handling of a resident's personal
2265 deposits by the director of a personal care home. Any funds given
2266 or provided for the purpose of supplying extra comforts,
2267 conveniences or services to any patient in any personal care home,
2268 and any funds otherwise received and held from, for or on behalf
2269 of any such resident, shall be deposited by the director or other
2270 proper officer of the personal care home to the credit of that
2271 patient in an account which shall be known as the Resident's
2272 Personal Deposit Fund. No more than one (1) month charge for the
2273 care, support, maintenance and medical attention of the patient
2274 shall be applied from such account at any one (1) time. After the
2275 death, discharge or transfer of any resident for whose benefit any
2276 such fund has been provided, any unexpended balance remaining in
2277 his personal deposit fund shall be applied for the payment of
2278 care, cost of support, maintenance and medical attention which is
2279 accrued. In the event any unexpended balance remains in that
2280 resident's personal deposit fund after complete reimbursement has
2281 been made for payment of care, support, maintenance and medical
2282 attention, and the director or other proper officer of the
2283 personal care home has been or shall be unable to locate the
2284 person or persons entitled to such unexpended balance, the

2285 director or other proper officer may, after the lapse of one (1)
2286 year from the date of such death, discharge or transfer, deposit
2287 the unexpended balance to the credit of the personal care home's
2288 operating fund.

2289 (c) The State Board of Health shall promulgate rules
2290 and regulations requiring personal care homes to maintain records
2291 relating to health condition, medicine dispensed and administered,
2292 and any reaction to such medicine. The director of the personal
2293 care home shall be responsible for explaining the availability of
2294 such records to the family of the resident at any time upon
2295 reasonable request.

2296 (d) The State Board of Health shall evaluate the
2297 effects of this section as it promotes adequate care of
2298 individuals in personal care homes in the interest of public
2299 health, safety and welfare. It shall report its findings to the
2300 Chairmen of the Public Health and Welfare Committees of the House
2301 and Senate by January 1, 2003. This subsection (4) shall stand
2302 repealed June 30, 2003.

2303 (5) (a) Pursuant to regulations promulgated by the State
2304 Department of Health, the licensing agency shall require to be
2305 performed a criminal history record check on every new employee of
2306 a licensed institution for the aged or infirm or care facility who
2307 provides direct patient care or services and who is employed after
2308 July 1, 2001. Except as otherwise provided, no such new employee
2309 shall be permitted to provide direct patient care or services
2310 until the results of the criminal history record check have
2311 revealed no disqualifying record. Every such new employee shall
2312 provide a valid current social security number and/or driver's
2313 license number which shall be furnished to the licensing agency or
2314 to the private entity designated by the licensing agency to
2315 conduct the criminal history record check. The institution for
2316 the aged or infirm or care facility applying for the criminal
2317 history record check will be promptly notified of any

2318 disqualifying record found by the criminal history record check.
2319 In order to determine the applicant's suitability for employment,
2320 the applicant shall be fingerprinted. If no disqualifying record
2321 is identified at the state level, the fingerprints shall be
2322 forwarded by the Department of Public Safety to the Federal Bureau
2323 of Investigation for a national criminal history record check.
2324 (b) A licensed institution for the aged or infirm or
2325 care facility may make an offer of temporary employment to a
2326 prospective employee pending the results of a criminal history
2327 record check on the person. In such instances, the licensed
2328 institution for the aged or infirm or care facility shall provide
2329 to the licensing agency, or to the designated private entity, the
2330 name and relevant information relating to the person within
2331 seventy-two (72) hours after the date the person accepts temporary
2332 employment.
2333 (c) All fees incurred in compliance with this section
2334 shall be borne by the institution or facility requesting the
2335 criminal history record check. The licensing agency, or the
2336 designated private entity, is authorized to charge the institution
2337 for the aged or infirm or care facility a fee which shall include
2338 the amount required by the Mississippi Department of Public
2339 Safety, the Federal Bureau of Investigation or any other agency
2340 designated by the licensing agency for the national criminal
2341 history record check in addition to any necessary costs incurred
2342 by the licensing agency or the designated private entity for the
2343 handling and administration of the criminal history record checks.
2344 Costs incurred by a nursing home provider implementing this act
2345 shall be reimbursed as an allowable cost under Section 43-13-116.
2346 (d) The licensing agency, care facility, and their
2347 agents, officers, employees, attorneys and representatives shall
2348 be presumed to be acting in good faith for any employment decision
2349 or action taken under paragraphs (a) and (b) of this subsection.

2350 The presumption of good faith may be overcome by a preponderance
2351 of the evidence in any civil action.
2352 (e) The licensing agency shall promulgate regulations
2353 to implement this subsection (5).
2354 **SECTION 9.** Section 15-1-36, Mississippi Code of 1972, is
2355 amended as follows:
2356 15-1-36. (1) For any claim accruing on or before June 30,
2357 1998, and except as otherwise provided in this section, no claim
2358 in tort may be brought against a licensed physician, osteopath,
2359 dentist, hospital <u>or nursing home or other long-term care</u>
2360 <u>facility</u>, nurse, pharmacist, podiatrist, optometrist or
2361 chiropractor for injuries or wrongful death arising out of the
2362 course of medical, surgical or other professional services unless
2363 it is filed within two (2) years from the date the alleged act,
2364 omission or neglect shall or with reasonable diligence might have
2365 been first known or discovered.
2366 (2) For any claim accruing on or after July 1, 1998, and
2367 except as otherwise provided in this section, no claim in tort may
2368 be brought against a licensed physician, osteopath, dentist,
2369 hospital <u>or nursing home or other long-term care hospital</u>, nurse,
2370 pharmacist, podiatrist, optometrist or chiropractor for injuries
2371 or wrongful death arising out of the course of medical, surgical
2372 or other professional services unless it is filed within two (2)
2373 years from the date the alleged act, omission or neglect shall or
2374 with reasonable diligence might have been first known or
2375 discovered, and, except as described in paragraphs (a) and (b) of
2376 this subsection, in no event more than seven (7) years after the
2377 alleged act, omission or neglect occurred:
2378 (a) In the event a foreign object introduced during a
2379 surgical or medical procedure has been left in a patient's body,
2380 the cause of action shall be deemed to have first accrued at, and
2381 not before, the time at which the foreign object is, or with

2382 reasonable diligence should have been, first known or discovered
2383 to be in the patient's body.
2384 (b) In the event the cause of action shall have been
2385 fraudulently concealed from the knowledge of the person entitled
2386 thereto, the cause of action shall be deemed to have first accrued
2387 at, and not before, the time at which such fraud shall be, or with
2388 reasonable diligence should have been, first known or discovered.
2389 (3) Except as otherwise provided in subsection (4) of this
2390 section, if at the time at which the cause of action shall or with
2391 reasonable diligence might have been first known or discovered,
2392 the person to whom such claim has accrued shall be six (6) years
2393 of age or younger, then such minor or the person claiming through
2394 such minor may, notwithstanding that the period of time limited
2395 pursuant to subsections (1) and (2) of this section shall have
2396 expired, commence action on such claim at any time within two (2)
2397 years next after the time at which the minor shall have reached
2398 his sixth birthday, or shall have died, whichever shall have first
2399 occurred.
2400 (4) If at the time at which the cause of action shall or
2401 with reasonable diligence might have been first known or
2402 discovered, the person to whom such claim has accrued shall be a
2403 minor without a parent or legal guardian, then such minor or the
2404 person claiming through such minor may, notwithstanding that the
2405 period of time limited pursuant to subsections (1) and (2) of this
2406 section shall have expired, commence action on such claim at any
2407 time within two (2) years next after the time at which the minor
2408 shall have a parent or legal guardian or shall have died,
2409 whichever shall have first occurred; provided, however, that in no
2410 event shall the period of limitation begin to run prior to such
2411 minor's sixth birthday unless such minor shall have died.
2412 (5) If at the time at which the cause of action shall or
2413 with reasonable diligence might have been first known or
2414 discovered, the person to whom such claim has accrued shall be

2415 under the disability of unsoundness of mind, then such person or
2416 the person claiming through him may, notwithstanding that the
2417 period of time hereinbefore limited shall have expired, commence
2418 action on such claim at any time within two (2) years next after
2419 the time at which the person to whom the right shall have first
2420 accrued shall have ceased to be under the disability, or shall
2421 have died, whichever shall have first occurred.

2422 (6) When any person who shall be under the disabilities
2423 mentioned in subsections (3), (4) and (5) of this section at the
2424 time at which his right shall have first accrued, shall depart
2425 this life without having ceased to be under such disability, no
2426 time shall be allowed by reason of the disability of such person
2427 to commence action on the claim of such person beyond the period
2428 prescribed under Section 15-1-55, Mississippi Code of 1972.

2429 (7) For the purposes of subsection (3) of this section, and
2430 only for the purposes of such subsection, the disability of
2431 infancy or minority shall be removed from and after a person has
2432 reached his sixth birthday.

2433 (8) For the purposes of subsection (4) of this section, and
2434 only for the purposes of such subsection, the disability of
2435 infancy or minority shall be removed from and after a person has
2436 reached his sixth birthday or from and after such person shall
2437 have a parent or legal guardian, whichever occurs later, unless
2438 such disability is otherwise removed by law.

2439 (9) The limitation established by this section as to a
2440 licensed physician, osteopath, dentist, hospital or nurse shall
2441 apply only to actions the cause of which accrued on or after July
2442 1, 1976.

2443 (10) The limitation established by this section as to
2444 pharmacists shall apply only to actions the cause of which accrued
2445 on or after July 1, 1978.

2446 (11) The limitation established by this section as to
2447 podiatrists shall apply only to actions the cause of which accrued
2448 on or after July 1, 1979.
2449 (12) The limitation established by this section as to
2450 optometrists and chiropractors shall apply only to actions the
2451 cause of which accrued on or after July 1, 1983.
2452 (13) The limitation established by this section as to
2453 actions commenced on behalf of minors shall apply only to actions
2454 the cause of which accrued on or after July 1, 1989.
2455 **SECTION 10.** Section 43-11-7, Mississippi Code of 1972, is
2456 amended as follows:
2457 43-11-7. Any person, as defined in this chapter, may apply
2458 for a license as provided herein. An application for a license
2459 shall be made to the licensing agency upon forms provided by it
2460 and shall contain such information as the licensing agency
2461 reasonably requires, which may include affirmative evidence of
2462 ability to comply with such reasonable standards, rules and
2463 regulations as are lawfully prescribed hereunder. Each
2464 application for a license for an institution for the aged or
2465 infirm, except for personal care homes, shall be accompanied by a
2466 license fee of Twenty Dollars ($20.00) for each bed in the
2467 institution, with a minimum fee per institution of Two Hundred
2468 Dollars ($200.00), which shall be paid to the licensing agency.
2469 Each application for a license for a personal care home shall be
2470 accompanied by a license fee of Fifteen Dollars ($15.00) for each
2471 bed in the institution, with a minimum fee per institution of One
2472 Hundred Dollars ($100.00), which shall be paid to the licensing
2473 agency.
2474 No governmental entity or agency shall be required to pay the
2475 fee or fees set forth in this section.
2476 **SECTION 11.** Section 43-7-53, Mississippi Code of 1972, is
2477 amended as follows:

2478 43-7-53. (1) There is hereby established within the
2479 Mississippi Council on Aging, the Office of the State Long-Term
2480 Care Facilities Ombudsman as provided by the Older Americans Act
2481 of 1965, as amended, 42 USCS 3001.
2482 (2) The council shall establish the qualifications of state
2483 and community ombudsmen. <u>Such qualifications shall include</u>
2484 <u>training and experience with long-term care facilities.</u>
2485 **SECTION 12.** Section 43-7-61, Mississippi Code of 1972, is
2486 amended as follows:
2487 43-7-61. (1) The Office of the State Long-Term Care
2488 Facilities Ombudsman shall establish a training and certification
2489 program. The council shall specify by rule the content of the
2490 training program. Each long-term care facilities ombudsman
2491 program shall bear the cost of training its own employees.
2492 (2) The State Ombudsman shall arrange for the training of
2493 all prospective community ombudsmen selected by area agencies on
2494 aging. Such training shall include instruction in at least the
2495 following subjects as they relate to long-term care:
2496 (a) The responsibilities and duties of community
2497 ombudsmen;
2498 (b) The laws and regulations governing the receipt,
2499 investigation and resolution of issues of the well-being of a
2500 resident;
2501 (c) The role of local, state and federal agencies that
2502 regulate long-term care facilities;
2503 (d) The different kinds of long-term care facilities in
2504 Mississippi and the services provided in each kind;
2505 (e) The special needs of the elderly and of the
2506 physically and mentally handicapped;
2507 (f) The role of the family, the sponsor, the legal
2508 representative, the physician, the church, and other public and
2509 private agencies, and the community;
2510 (g) How to work with long-term care facility staff;

2511 (h) The aging process and characteristics of the
2512 long-term care facility resident or institutionalized elderly;
2513 (i) Familiarity with and access to information
2514 concerning the laws and regulations governing Medicare, Medicaid,
2515 Social Security, Supplemental Security Income, the Veterans
2516 Administration and Workers' Compensation; and
2517 (j) The training program shall include an appropriate
2518 internship to be performed in a long-term care facility.
2519 (3) Persons selected by area agencies on aging who have
2520 satisfactorily completed the training arranged by the State
2521 Ombudsman shall be certified as community ombudsmen by the
2522 council.
2523 (4) Each area agency on aging may appoint an advisory
2524 committee to advise it in the operation of its community ombudsman
2525 program. The number and qualifications of members of the advisory
2526 committee shall be determined by the area agency on aging.
2527 (5) Ombudsmen who have successfully completed the training
2528 and certification program under this section shall be given
2529 identification cards which shall be presented to employees of a
2530 long-term care facility upon request.
2531 (6) Ombudsmen shall participate in ongoing training programs
2532 related to their duties or responsibilities.
2533 **SECTION 13.** Actions against nursing homes and other
2534 long-term care providers for injury or damages or wrongful death
2535 whether in contract or tort-based on an alleged breach of the
2536 standard of care must be brought in the county wherein the act or
2537 omission constituting the alleged breach of the standard of care
2538 by the defendant actually occurred. If the act or omissions took
2539 place in more than one (1) county within the State of Mississippi,
2540 the action must be brought in the county wherein the plaintiff
2541 resided at the time of the act or omission, if the action is one
2542 for personal injuries, or wherein the plaintiff's decedent resided
2543 at the time of the act or omission if the action is one for

2544 wrongful death. If at any time prior to the commencement of the
2545 trial of the action it is shown that the plaintiff's injuries or
2546 plaintiff's decedent's death did not result from acts or omissions
2547 which took place in more than one (1) county, on motion of any
2548 defendant the court shall transfer the action to such county
2549 wherein the alleged acts or omissions actually occurred. If an
2550 action is brought in an improper county, such action may be
2551 transferred to the proper county pursuant to Section 11-11-17.
2552 **SECTION 14.** This act shall take effect and be in force from
2553 and after its passage.