

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

To: Public Health and
Welfare; Appropriations

SENATE BILL NO. 2346
(As Passed the Senate)

1 AN ACT RELATIVE TO THE MISSISSIPPI MEDICAID ASSISTANCE
2 PROGRAM; TO AMEND SECTION 43-13-113, MISSISSIPPI CODE OF 1972, TO
3 AUTHORIZE THE DIVISION OF MEDICAID TO OBTAIN A LINE OF CREDIT FROM
4 THE WORKING CASH-STABILIZATION FUND OR OTHER SPECIAL SOURCE FUNDS
5 FOR BUDGET SHORTFALLS; TO AMEND SECTION 43-13-115, MISSISSIPPI
6 CODE OF 1972, TO CLARIFY ELIGIBILITY FOR MEDICAID ASSISTANCE, TO
7 AUTHORIZE THE DIVISION OF MEDICAID TO APPLY FOR APPLICABLE WAIVERS
8 FOR BENEFITS AND BUY-IN OPTIONS FOR THE DISABLED CHILDREN LIVING
9 AT HOME AND POVERTY LEVEL AGED AND DISABLED (PLADS) ELIGIBILITY
10 CATEGORIES AND TO ESTABLISH AN EXPENDITURE/ENROLLMENT CAP FOR
11 THESE CATEGORIES; TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF
12 1972, TO REDUCE THE NURSING FACILITY BED DAYS ELIGIBLE FOR
13 MEDICAID REIMBURSEMENT, TO AUTHORIZE THE DIVISION TO DEVELOP AN
14 ASSESSMENT PROCESS FOR LONG-TERM CARE SERVICES AND DELETE THE
15 REFERRAL PHYSICIAN CERTIFICATION PROCESS, TO DELETE THE NECESSITY
16 TO COMPARE HOME HEALTH COSTS TO NURSING FACILITY SERVICES FOR
17 REIMBURSEMENT, TO DELETE AUTHORITY FOR THE DIVISION TO OPT OUT OF
18 THE FEDERAL DRUG REBATE PROGRAM AND CREATE A CLOSED DRUG
19 FORMULARY, TO DIRECT THE DIVISION TO IMPLEMENT A PREFERRED DRUG
20 LIST (PDL), TO DIRECT THE DIVISION TO DEVELOP A STATE MAXIMUM
21 ALLOWABLE COST (MAC) PRICING SCHEDULE FOR DRUG REIMBURSEMENT, TO
22 DELETE PRIOR APPROVAL OF MONTHLY DRUG PRESCRIPTIONS OVER FIVE, TO
23 PROVIDE THAT CERTAIN ANTIPSYCHOTIC DRUGS SHALL BE INCLUDED IN ANY
24 PREFERRED DRUG LIST DEVELOPED BY THE DIVISION OF MEDICAID AND
25 SHALL NOT REQUIRE PRIOR AUTHORIZATION FOR MEDICAID REIMBURSEMENT,
26 TO ALLOW A DISPENSING FEE FOR OVER-THE-COUNTER DRUGS, TO REDUCE
27 THE ICF/MR BED DAYS ELIGIBLE FOR REIMBURSEMENT, TO DELETE CERTAIN
28 RESTRICTIONS ON THE HOME- AND COMMUNITY-BASED SERVICES WAIVER
29 PROGRAM, TO DIRECT THE DIVISION TO PAY A FLAT FEE FOR NONEMERGENCY
30 TRANSPORTATION SERVICES OR IN THE ALTERNATIVE REIMBURSE ACTUAL
31 MILES TRAVELED AND TO APPLY FOR WAIVERS TO DRAW FEDERAL FUNDS FOR
32 NONEMERGENCY TRANSPORTATION AS A COVERED SERVICE, TO DELETE THE
33 AUTHORITY FOR REIMBURSEMENT FOR BIRTHING CENTER SERVICES, TO
34 CLARIFY THE ASSISTED LIVING SERVICES WAIVER PROVISION, TO GIVE THE
35 DIVISION DISCRETION IN PAYING MEDICARE COINSURANCE AMOUNTS, TO
36 AUTHORIZE CHILDREN UP TO TWO YEARS OF AGE FOR THE OBSTETRICAL CARE
37 WAIVER PROGRAM, TO DELETE CERTAIN RESTRICTIONS IN THE DISEASE
38 MANAGEMENT PROGRAM AUTHORITY, TO REMOVE THE 5% REIMBURSEMENT
39 REDUCTION FOR CASE MANAGEMENT SERVICES UNDER THE HOME- AND
40 COMMUNITY-BASED PROGRAM PROVIDED BY A PLANNING AND DEVELOPMENT
41 DISTRICT (PDD) AND TO PRESCRIBE A RATE OF REIMBURSEMENT FOR SUCH
42 SERVICES AND A FUNDS TRANSFER REQUIREMENT, AND TO AUTHORIZE THE
43 DIVISION TO REMOVE THE 5% REDUCTION IN REIMBURSEMENT FOR PROVIDERS
44 WHO PARTICIPATE IN THE EMERGENCY ROOM REDIRECTION PROGRAM; TO
45 AMEND SECTION 43-13-122, MISSISSIPPI CODE OF 1972, TO DELETE
46 CERTAIN OBSOLETE LANGUAGE; TO AMEND SECTION 43-13-107, MISSISSIPPI
47 CODE OF 1972, TO AUTHORIZE THE DIVISION TO SUBMIT EMERGENCY DRUG
48 ISSUES TO THE PHARMACY AND THERAPEUTICS COMMITTEE WITHOUT PUBLIC
49 COMMENT; TO AMEND SECTION 43-13-145, MISSISSIPPI CODE OF 1972, TO
50 INCREASE THE PER BED ASSESSMENT LEVIED UPON NURSING FACILITIES FOR
51 SUPPORT OF THE MEDICAID PROGRAM; TO AMEND SECTION 41-7-191,
52 MISSISSIPPI CODE OF 1972, TO PROHIBIT THE STATE DEPARTMENT OF



53 HEALTH FROM ISSUING A CERTIFICATE OF NEED FOR THE ADDITION,
54 CONSTRUCTION OR CONVERSION OF ANY NURSING FACILITY BEDS AFTER THE
55 EFFECTIVE DATE OF THIS ACT, AND TO INCLUDE HOME- AND
56 COMMUNITY-BASED SERVICES IN THE STATE HEALTH PLAN FOR LONG-TERM
57 CARE CON PURPOSES; AND FOR RELATED PURPOSES.

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

59 **SECTION 1.** Section 43-13-113, Mississippi Code of 1972, is
60 amended as follows:

61 43-13-113. (1) The State Treasurer shall receive on behalf
62 of the state, and execute all instruments incidental thereto,
63 federal and other funds to be used for financing the medical
64 assistance plan or program adopted pursuant to this article, and
65 place all such funds in a special account to the credit of the
66 Governor's Office-Division of Medicaid, which funds shall be
67 expended by the division for the purposes and under the provisions
68 of this article, and shall be paid out by the State Treasurer as
69 funds appropriated to carry out the provisions of this article are
70 paid out by him.

71 The division shall issue all checks or electronic transfers
72 for administrative expenses, and for medical assistance under the
73 provisions of this article. All such checks or electronic
74 transfers shall be drawn upon funds made available to the division
75 by the State Auditor, upon requisition of the director. It is the
76 purpose of this section to provide that the State Auditor shall
77 transfer, in lump sums, amounts to the division for disbursement
78 under the regulations which shall be made by the director with the
79 approval of the Governor; however, the division, or its fiscal
80 agent in behalf of the division, shall be authorized in
81 maintaining separate accounts with a Mississippi bank to handle
82 claim payments, refund recoveries and related Medicaid program
83 financial transactions, to aggressively manage the float in these
84 accounts while awaiting clearance of checks or electronic
85 transfers and/or other disposition so as to accrue maximum
86 interest advantage of the funds in the account, and to retain all



87 earned interest on these funds to be applied to match federal
88 funds for Medicaid program operations.

89 (2) The division is authorized to obtain a line of credit
90 through the State Treasurer from the Working Cash-Stabilization
91 Fund or any other special source funds maintained in the State
92 Treasury in an amount not exceeding Ten Million Dollars
93 (\$10,000,000.00) to fund shortfalls which, from time to time, may
94 occur due to decreases in state matching fund cash flow. The
95 length of indebtedness under this provision shall not carry past
96 the end of the quarter following the loan origination. Loan
97 proceeds shall be received by the State Treasurer and shall be
98 placed in a Medicaid designated special fund account. Loan
99 proceeds shall be expended only for health care services provided
100 under the Medicaid program. The division may pledge as security
101 for such interim financing future funds that will be received by
102 the division. Any such loans shall be repaid from the first
103 available funds received by the division in the manner of and
104 subject to the same terms provided in this section.

105 (3) Disbursement of funds to providers shall be made as
106 follows:

107 (a) All providers must submit all claims to the
108 Division of Medicaid's fiscal agent no later than twelve (12)
109 months from the date of service.

110 (b) The Division of Medicaid's fiscal agent must pay
111 ninety percent (90%) of all clean claims within thirty (30) days
112 of the date of receipt.

113 (c) The Division of Medicaid's fiscal agent must pay
114 ninety-nine percent (99%) of all clean claims within ninety (90)
115 days of the date of receipt.

116 (d) The Division of Medicaid's fiscal agent must pay
117 all other claims within twelve (12) months of the date of receipt.

118 (e) If a claim is neither paid nor denied for valid and
119 proper reasons by the end of the time periods as specified above,



120 the Division of Medicaid's fiscal agent must pay the provider
121 interest on the claim at the rate of one and one-half percent
122 (1-1/2%) per month on the amount of such claim until it is finally
123 settled or adjudicated.

124 (4) The date of receipt is the date the fiscal agent
125 receives the claim as indicated by its date stamp on the claim or,
126 for those claims filed electronically, the date of receipt is the
127 date of transmission.

128 (5) The date of payment is the date of the check or, for
129 those claims paid by electronic funds transfer, the date of the
130 transfer.

131 (6) The above specified time limitations do not apply in the
132 following circumstances:

133 (a) Retroactive adjustments paid to providers
134 reimbursed under a retrospective payment system;

135 (b) If a claim for payment under Medicare has been
136 filed in a timely manner, the fiscal agent may pay a Medicaid
137 claim relating to the same services within six (6) months after
138 it, or the provider, receives notice of the disposition of the
139 Medicare claim;

140 (c) Claims from providers under investigation for fraud
141 or abuse; and

142 (d) The Division of Medicaid and/or its fiscal agent
143 may make payments at any time in accordance with a court order, to
144 carry out hearing decisions or corrective actions taken to resolve
145 a dispute, or to extend the benefits of a hearing decision,
146 corrective action, or court order to others in the same situation
147 as those directly affected by it.

148 (7) Repealed.

149 (8) If sufficient funds are appropriated therefor by the
150 Legislature, the Division of Medicaid may contract with the
151 Mississippi Dental Association, or an approved designee, to
152 develop and operate a Donated Dental Services (DDS) program



153 through which volunteer dentists will treat needy disabled, aged
154 and medically-compromised individuals who are non-Medicaid
155 eligible recipients.

156 **SECTION 2.** Section 43-13-115, Mississippi Code of 1972, is
157 amended as follows:

158 43-13-115. Recipients of medical assistance shall be the
159 following persons only:

160 (1) Who are qualified for public assistance grants
161 under provisions of Title IV-A and E of the federal Social
162 Security Act, as amended, as determined by the State Department of
163 Human Services, including those statutorily deemed to be IV-A and
164 low-income families and children under Section 1931 of the Social
165 Security Act as determined by the State Department of Human
166 Services and certified to the Division of Medicaid, but not
167 optional groups except as specifically covered in this section.
168 For the purposes of this paragraph (1) and paragraphs (8), (17)
169 and (18) of this section, any reference to Title IV-A or to Part A
170 of Title IV of the federal Social Security Act, as amended, or the
171 state plan under Title IV-A or Part A of Title IV, shall be
172 considered as a reference to Title IV-A of the federal Social
173 Security Act, as amended, and the state plan under Title IV-A,
174 including the income and resource standards and methodologies
175 under Title IV-A and the state plan, as they existed on July 16,
176 1996.

177 (2) Those qualified for Supplemental Security Income
178 (SSI) benefits under Title XVI of the federal Social Security Act,
179 as amended, and those who are deemed SSI eligible as contained in
180 federal statute. The eligibility of individuals covered in this
181 paragraph shall be determined by the Social Security
182 Administration and certified to the Division of Medicaid.

183 (3) Qualified pregnant women who would be eligible for
184 medical assistance as a low income family member under Section
185 1931 of the Social Security Act if her child was born.



186 (4) [Deleted]

187 (5) A child born on or after October 1, 1984, to a
188 woman eligible for and receiving medical assistance under the
189 state plan on the date of the child's birth shall be deemed to
190 have applied for medical assistance and to have been found
191 eligible for such assistance under such plan on the date of such
192 birth and will remain eligible for such assistance for a period of
193 one (1) year so long as the child is a member of the woman's
194 household and the woman remains eligible for such assistance or
195 would be eligible for assistance if pregnant. The eligibility of
196 individuals covered in this paragraph shall be determined by the
197 State Department of Human Services and certified to the Division
198 of Medicaid.

199 (6) Children certified by the State Department of Human
200 Services to the Division of Medicaid of whom the state and county
201 human services agency has custody and financial responsibility,
202 and children who are in adoptions subsidized in full or part by
203 the Department of Human Services, including special needs children
204 in non-Title IV-E adoption assistance, who are approvable under
205 Title XIX of the Medicaid program.

206 (7) (a) Persons certified by the Division of Medicaid
207 who are patients in a medical facility (nursing home, hospital,
208 tuberculosis sanatorium or institution for treatment of mental
209 diseases), and who, except for the fact that they are patients in
210 such medical facility, would qualify for grants under Title IV,
211 supplementary security income benefits under Title XVI or state
212 supplements, and those aged, blind and disabled persons who would
213 not be eligible for supplemental security income benefits under
214 Title XVI or state supplements if they were not institutionalized
215 in a medical facility but whose income is below the maximum
216 standard set by the Division of Medicaid, which standard shall not
217 exceed that prescribed by federal regulation;



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

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

229 (9) Individuals who are:

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

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

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

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

245 (10) Certain disabled children age eighteen (18) or
246 under who are living at home, who would be eligible, if in a
247 medical institution, for SSI or a state supplemental payment under
248 Title XVI of the federal Social Security Act, as amended, and
249 therefore for Medicaid under the plan, and for whom the state has
250 made a determination as required under Section 1902(e)(3)(b) of



251 the federal Social Security Act, as amended. The eligibility of
252 individuals under this paragraph shall be determined by the
253 Division of Medicaid; provided, however, that the division may
254 apply to the Center for Medicare and Medicaid Services (CMS) for a
255 waiver that will allow flexibility in the benefit design for the
256 Disabled Children Living at Home eligibility category authorized
257 herein, and the division may establish an expenditure/enrollment
258 cap for this category. Nothing contained in this paragraph (10)
259 shall entitle an individual for benefits.

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

267 The eligibility of individuals covered under this paragraph
268 shall be determined by the Division of Medicaid; provided,
269 however, that the division may apply to the Center for Medicare
270 and Medicaid Services (CMS) for a waiver that will allow
271 flexibility in the benefit design and buy-in options for the
272 Poverty Level Aged and Disabled (PLAD) eligibility category
273 authorized herein, and the division may establish an
274 expenditure/enrollment cap for this category. Nothing contained
275 in this paragraph (11) shall entitle an individual for benefits.

276 (12) Individuals who are qualified Medicare
277 beneficiaries (QMB) entitled to Part A Medicare as defined under
278 Section 301, Public Law 100-360, known as the Medicare
279 Catastrophic Coverage Act of 1988, and whose income does not
280 exceed one hundred percent (100%) of the nonfarm official poverty
281 line as defined by the Office of Management and Budget and revised
282 annually.



283 The eligibility of individuals covered under this paragraph
284 shall be determined by the Division of Medicaid, and such
285 individuals determined eligible shall receive Medicare
286 cost-sharing expenses only as more fully defined by the Medicare
287 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
288 1997.

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

296 * * *

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

299 (14) [Deleted]

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

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



315 (17) In accordance with the terms of the federal
316 Personal Responsibility and Work Opportunity Reconciliation Act of
317 1996 (Public Law 104-193), persons who become ineligible for
318 assistance under Title IV-A of the federal Social Security Act, as
319 amended, because of increased income from or hours of employment
320 of the caretaker relative or because of the expiration of the
321 applicable earned income disregards, who were eligible for
322 Medicaid for at least three (3) of the six (6) months preceding
323 the month in which such ineligibility begins, shall be eligible
324 for Medicaid assistance for up to twelve (12) months * * *.

325 (18) Persons who become ineligible for assistance under
326 Title IV-A of the federal Social Security Act, as amended, as a
327 result, in whole or in part, of the collection or increased
328 collection of child or spousal support under Title IV-D of the
329 federal Social Security Act, as amended, who were eligible for
330 Medicaid for at least three (3) of the six (6) months immediately
331 preceding the month in which such ineligibility begins, shall be
332 eligible for Medicaid for an additional four (4) months beginning
333 with the month in which such ineligibility begins.

334 (19) Disabled workers, whose incomes are above the
335 Medicaid eligibility limits, but below two hundred fifty percent
336 (250%) of the federal poverty level, shall be allowed to purchase
337 Medicaid coverage on a sliding fee scale developed by the Division
338 of Medicaid.

339 (20) Medicaid eligible children under age eighteen (18)
340 shall remain eligible for Medicaid benefits until the end of a
341 period of twelve (12) months following an eligibility
342 determination, or until such time that the individual exceeds age
343 eighteen (18).

344 (21) Women of childbearing age whose family income does
345 not exceed one hundred eighty-five percent (185%) of the federal
346 poverty level. The eligibility of individuals covered under this
347 paragraph (21) shall be determined by the Division of Medicaid,



348 and those individuals determined eligible shall only receive
349 family planning services covered under Section 43-13-117(13) and
350 not any other services covered under Medicaid. However, any
351 individual eligible under this paragraph (21) who is also eligible
352 under any other provision of this section shall receive the
353 benefits to which he or she is entitled under that other
354 provision, in addition to family planning services covered under
355 Section 43-13-117(13).

356 The Division of Medicaid shall apply to the United States
357 Secretary of Health and Human Services for a federal waiver of the
358 applicable provisions of Title XIX of the federal Social Security
359 Act, as amended, and any other applicable provisions of federal
360 law as necessary to allow for the implementation of this paragraph
361 (21). The provisions of this paragraph (21) shall be implemented
362 from and after the date that the Division of Medicaid receives the
363 federal waiver.

364 (22) Persons who are workers with a potentially severe
365 disability, as determined by the division, shall be allowed to
366 purchase Medicaid coverage. The term "worker with a potentially
367 severe disability" means a person who is at least sixteen (16)
368 years of age but under sixty-five (65) years of age, who has a
369 physical or mental impairment that is reasonably expected to cause
370 the person to become blind or disabled as defined under Section
371 1614(a) of the federal Social Security Act, as amended, if the
372 person does not receive items and services provided under
373 Medicaid.

374 The eligibility of persons under this paragraph (22) shall be
375 conducted as a demonstration project that is consistent with
376 Section 204 of the Ticket to Work and Work Incentives Improvement
377 Act of 1999, Public Law 106-170, for a certain number of persons
378 as specified by the division. The eligibility of individuals
379 covered under this paragraph (22) shall be determined by the
380 Division of Medicaid.



381 * * *

382 (23) Children certified by the Mississippi Department
383 of Human Services for whom the state and county human services
384 agency has custody and financial responsibility who are in foster
385 care on their eighteenth birthday as reported by the Mississippi
386 Department of Human Services shall be certified Medicaid eligible
387 by the Division of Medicaid until their twenty-first birthday.

388 (24) Individuals who have not attained age sixty-five
389 (65), are not otherwise covered by creditable coverage as defined
390 in the Public Health Services Act, and have been screened for
391 breast and cervical cancer under the Centers for Disease Control
392 and Prevention Breast and Cervical Cancer Early Detection Program
393 established under Title XV of the Public Health Service Act in
394 accordance with the requirements of that act and who need
395 treatment for breast or cervical cancer. Eligibility of
396 individuals under this paragraph (24) shall be determined by the
397 Division of Medicaid.

398 * * *

399 **SECTION 3.** Section 43-13-117, Mississippi Code of 1972, is
400 amended as follows:

401 43-13-117. Medicaid as authorized by this article shall
402 include payment of part or all of the costs, at the discretion of
403 the division or its successor, with approval of the Governor, of
404 the following types of care and services rendered to eligible
405 applicants who have been determined to be eligible for that care
406 and services, within the limits of state appropriations and
407 federal matching funds:

408 (1) Inpatient hospital services.

409 (a) The division shall allow thirty (30) days of
410 inpatient hospital care annually for all Medicaid recipients.
411 Precertification of inpatient days must be obtained as required by
412 the division. The division may allow unlimited days in
413 disproportionate hospitals as defined by the division for eligible



414 infants under the age of six (6) years if certified as medically
415 necessary as required by the division.

416 (b) From and after July 1, 1994, the Executive
417 Director of the Division of Medicaid shall amend the Mississippi
418 Title XIX Inpatient Hospital Reimbursement Plan to remove the
419 occupancy rate penalty from the calculation of the Medicaid
420 Capital Cost Component utilized to determine total hospital costs
421 allocated to the Medicaid program.

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

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

434 (3) Laboratory and x-ray services.

435 (4) Nursing facility services.

436 (a) The division shall make full payment to
437 nursing facilities for each day, not exceeding thirty (30) days
438 per year, that a patient is absent from the facility on home
439 leave. Payment may be made for the following home leave days in
440 addition to the thirty-day limitation: Christmas, the day before
441 Christmas, the day after Christmas, Thanksgiving, the day before
442 Thanksgiving and the day after Thanksgiving.

443 (b) From and after July 1, 1997, the division
444 shall implement the integrated case-mix payment and quality
445 monitoring system, which includes the fair rental system for
446 property costs and in which recapture of depreciation is



447 eliminated. The division may reduce the payment for hospital
448 leave and therapeutic home leave days to the lower of the case-mix
449 category as computed for the resident on leave using the
450 assessment being utilized for payment at that point in time, or a
451 case-mix score of 1.000 for nursing facilities, and shall compute
452 case-mix scores of residents so that only services provided at the
453 nursing facility are considered in calculating a facility's per
454 diem.

455 During the period between May 1, 2002, and December 1, 2002,
456 the Chairmen of the Public Health and Welfare Committees of the
457 Senate and the House of Representatives may appoint a joint study
458 committee to consider the issue of setting uniform reimbursement
459 rates for nursing facilities. The study committee will consist of
460 the Chairmen of the Public Health and Welfare Committees, three
461 (3) members of the Senate and three (3) members of the House. The
462 study committee shall complete its work in not more than three (3)
463 meetings.

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

467 (d) When a facility of a category that does not
468 require a certificate of need for construction and that could not
469 be eligible for Medicaid reimbursement is constructed to nursing
470 facility specifications for licensure and certification, and the
471 facility is subsequently converted to a nursing facility under a
472 certificate of need that authorizes conversion only and the
473 applicant for the certificate of need was assessed an application
474 review fee based on capital expenditures incurred in constructing
475 the facility, the division shall allow reimbursement for capital
476 expenditures necessary for construction of the facility that were
477 incurred within the twenty-four (24) consecutive calendar months
478 immediately preceding the date that the certificate of need
479 authorizing the conversion was issued, to the same extent that



480 reimbursement would be allowed for construction of a new nursing
481 facility under a certificate of need that authorizes that
482 construction. The reimbursement authorized in this subparagraph
483 (d) may be made only to facilities the construction of which was
484 completed after June 30, 1989. Before the division shall be
485 authorized to make the reimbursement authorized in this
486 subparagraph (d), the division first must have received approval
487 from the Health Care Financing Administration of the United States
488 Department of Health and Human Services of the change in the state
489 Medicaid plan providing for the reimbursement.

490 (e) The division shall develop and implement, not
491 later than January 1, 2001, a case-mix payment add-on determined
492 by time studies and other valid statistical data that will
493 reimburse a nursing facility for the additional cost of caring for
494 a resident who has a diagnosis of Alzheimer's or other related
495 dementia and exhibits symptoms that require special care. Any
496 such case-mix add-on payment shall be supported by a determination
497 of additional cost. The division shall also develop and implement
498 as part of the fair rental reimbursement system for nursing
499 facility beds, an Alzheimer's resident bed depreciation enhanced
500 reimbursement system that will provide an incentive to encourage
501 nursing facilities to convert or construct beds for residents with
502 Alzheimer's or other related dementia.

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

505 * * *

506 The division shall apply for necessary federal waivers to
507 assure that additional services providing alternatives to nursing
508 facility care are made available to applicants for nursing
509 facility care.

510 (5) Periodic screening and diagnostic services for
511 individuals under age twenty-one (21) years as are needed to
512 identify physical and mental defects and to provide health care



513 treatment and other measures designed to correct or ameliorate
514 defects and physical and mental illness and conditions discovered
515 by the screening services regardless of whether these services are
516 included in the state plan. The division may include in its
517 periodic screening and diagnostic program those discretionary
518 services authorized under the federal regulations adopted to
519 implement Title XIX of the federal Social Security Act, as
520 amended. The division, in obtaining physical therapy services,
521 occupational therapy services, and services for individuals with
522 speech, hearing and language disorders, may enter into a
523 cooperative agreement with the State Department of Education for
524 the provision of those services to handicapped students by public
525 school districts using state funds that are provided from the
526 appropriation to the Department of Education to obtain federal
527 matching funds through the division. The division, in obtaining
528 medical and psychological evaluations for children in the custody
529 of the State Department of Human Services may enter into a
530 cooperative agreement with the State Department of Human Services
531 for the provision of those services using state funds that are
532 provided from the appropriation to the Department of Human
533 Services to obtain federal matching funds through the division.

534 (6) Physician's services. The division shall allow
535 twelve (12) physician visits annually. All fees for physicians'
536 services that are covered only by Medicaid shall be reimbursed at
537 ninety percent (90%) of the rate established on January 1, 1999,
538 and as adjusted each January thereafter, under Medicare (Title
539 XVIII of the Social Security Act, as amended), and which shall in
540 no event be less than seventy percent (70%) of the rate
541 established on January 1, 1994. All fees for physicians' services
542 that are covered by both Medicare and Medicaid shall be reimbursed
543 at ten percent (10%) of the adjusted Medicare payment established
544 on January 1, 1999, and as adjusted each January thereafter, under
545 Medicare (Title XVIII of the Social Security Act, as amended), and



546 which shall in no event be less than seventy percent (70%) of the
547 adjusted Medicare payment established on January 1, 1994.

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

551 (b) Repealed.

552 (8) Emergency medical transportation services. On
553 January 1, 1994, emergency medical transportation services shall
554 be reimbursed at seventy percent (70%) of the rate established
555 under Medicare (Title XVIII of the Social Security Act, as
556 amended). "Emergency medical transportation services" shall mean,
557 but shall not be limited to, the following services by a properly
558 permitted ambulance operated by a properly licensed provider in
559 accordance with the Emergency Medical Services Act of 1974
560 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
561 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
562 (vi) disposable supplies, (vii) similar services.

563 (9) (a) Legend and other drugs as may be determined by
564 the division. The division shall contract for full scope pharmacy
565 benefit management services and shall implement a preferred drug
566 list (PDL). The division may implement a program of prior
567 approval for drugs to the extent permitted by law. The division
568 shall allow seven (7) prescriptions per month for each
569 noninstitutionalized Medicaid recipient. * * * The division shall
570 not reimburse for any portion of a prescription that exceeds a
571 thirty-four-day supply of the drug based on the daily dosage.

572 * * *

573 Provided, however, that any A-typical antipsychotic drug
574 shall be included in any preferred drug list developed by the
575 Division of Medicaid and shall not require prior authorization,
576 and any licensed physician may prescribe any A-typical
577 antipsychotic drug deemed appropriate for Medicaid recipients
578 which shall be fully eligible for Medicaid reimbursement.



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

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

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

592 (b) * * * Payment by the division for covered
593 multiple source drugs shall be limited to the lower of the upper
594 limits established and published by the Centers for Medicare and
595 Medicaid Services (CMS) plus a dispensing fee, or the estimated
596 acquisition cost (EAC) plus a dispensing fee, or the providers'
597 usual and customary charge to the general public. * * *

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

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

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

609 The Medicaid provider shall not prescribe, the Medicaid
610 pharmacy shall not bill, and the division shall not reimburse for
611 name brand drugs if there are equally effective generic



612 equivalents available and if the generic equivalents are the least
613 expensive.

614 * * *

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

618 The division shall develop a state Maximum Allowable Cost
619 (MAC) pricing schedule for selected drugs in order to reduce the
620 cost of the pharmacy program as soon as practicable.

621 * * *

622 (10) Dental care that is an adjunct to treatment of an
623 acute medical or surgical condition; services of oral surgeons and
624 dentists in connection with surgery related to the jaw or any
625 structure contiguous to the jaw or the reduction of any fracture
626 of the jaw or any facial bone; and emergency dental extractions
627 and treatment related thereto. On July 1, 1999, all fees for
628 dental care and surgery under authority of this paragraph (10)
629 shall be increased to one hundred sixty percent (160%) of the
630 amount of the reimbursement rate that was in effect on June 30,
631 1999. It is the intent of the Legislature to encourage more
632 dentists to participate in the Medicaid program.

633 (11) Eyeglasses for all Medicaid beneficiaries who have
634 (a) had surgery on the eyeball or ocular muscle that results in a
635 vision change for which eyeglasses or a change in eyeglasses is
636 medically indicated within six (6) months of the surgery and is in
637 accordance with policies established by the division, or (b) one
638 (1) pair every five (5) years and in accordance with policies
639 established by the division. In either instance, the eyeglasses
640 must be prescribed by a physician skilled in diseases of the eye
641 or an optometrist, whichever the beneficiary may select.

642 (12) Intermediate care facility services.

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



645 day, not exceeding sixty (60) days per year, that a patient is
646 absent from the facility on home leave. Payment may be made for
647 the following home leave days in addition to the sixty-day
648 limitation: Christmas, the day before Christmas, the day after
649 Christmas, Thanksgiving, the day before Thanksgiving and the day
650 after Thanksgiving.

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

654 (13) Family planning services, including drugs,
655 supplies and devices, when those services are under the
656 supervision of a physician.

657 (14) Clinic services. Such diagnostic, preventive,
658 therapeutic, rehabilitative or palliative services furnished to an
659 outpatient by or under the supervision of a physician or dentist
660 in a facility that is not a part of a hospital but that is
661 organized and operated to provide medical care to outpatients.
662 Clinic services shall include any services reimbursed as
663 outpatient hospital services that may be rendered in such a
664 facility, including those that become so after July 1, 1991. On
665 July 1, 1999, all fees for physicians' services reimbursed under
666 authority of this paragraph (14) shall be reimbursed at ninety
667 percent (90%) of the rate established on January 1, 1999, and as
668 adjusted each January thereafter, under Medicare (Title XVIII of
669 the Social Security Act, as amended), and which shall in no event
670 be less than seventy percent (70%) of the rate established on
671 January 1, 1994. All fees for physicians' services that are
672 covered by both Medicare and Medicaid shall be reimbursed at ten
673 percent (10%) of the adjusted Medicare payment established on
674 January 1, 1999, and as adjusted each January thereafter, under
675 Medicare (Title XVIII of the Social Security Act, as amended), and
676 which shall in no event be less than seventy percent (70%) of the
677 adjusted Medicare payment established on January 1, 1994. On July



678 1, 1999, all fees for dentists' services reimbursed under
679 authority of this paragraph (14) shall be increased to one hundred
680 sixty percent (160%) of the amount of the reimbursement rate that
681 was in effect on June 30, 1999.

682 (15) Home- and community-based services for the elderly
683 and disabled, as provided under Title XIX of the federal Social
684 Security Act, as amended, under waivers, subject to the
685 availability of funds specifically appropriated therefor by the
686 Legislature. * * *

687 (16) Mental health services. Approved therapeutic and
688 case management services (a) provided by an approved regional
689 mental health/retardation center established under Sections
690 41-19-31 through 41-19-39, or by another community mental health
691 service provider meeting the requirements of the Department of
692 Mental Health to be an approved mental health/retardation center
693 if determined necessary by the Department of Mental Health, using
694 state funds that are provided from the appropriation to the State
695 Department of Mental Health and/or funds transferred to the
696 department by a political subdivision or instrumentality of the
697 state and used to match federal funds under a cooperative
698 agreement between the division and the department, or (b) provided
699 by a facility that is certified by the State Department of Mental
700 Health to provide therapeutic and case management services, to be
701 reimbursed on a fee for service basis, or (c) provided in the
702 community by a facility or program operated by the Department of
703 Mental Health. Any such services provided by a facility described
704 in subparagraph (b) must have the prior approval of the division
705 to be reimbursable under this section. After June 30, 1997,
706 mental health services provided by regional mental
707 health/retardation centers established under Sections 41-19-31
708 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
709 and/or their subsidiaries and divisions, or by psychiatric
710 residential treatment facilities as defined in Section 43-11-1, or



711 by another community mental health service provider meeting the
712 requirements of the Department of Mental Health to be an approved
713 mental health/retardation center if determined necessary by the
714 Department of Mental Health, shall not be included in or provided
715 under any capitated managed care pilot program provided for under
716 paragraph (24) of this section.

717 (17) Durable medical equipment services and medical
718 supplies. Precertification of durable medical equipment and
719 medical supplies must be obtained as required by the division.
720 The Division of Medicaid may require durable medical equipment
721 providers to obtain a surety bond in the amount and to the
722 specifications as established by the Balanced Budget Act of 1997.

723 (18) (a) Notwithstanding any other provision of this
724 section to the contrary, the division shall make additional
725 reimbursement to hospitals that serve a disproportionate share of
726 low-income patients and that meet the federal requirements for
727 those payments as provided in Section 1923 of the federal Social
728 Security Act and any applicable regulations. However, from and
729 after January 1, 1999, no public hospital shall participate in the
730 Medicaid disproportionate share program unless the public hospital
731 participates in an intergovernmental transfer program as provided
732 in Section 1903 of the federal Social Security Act and any
733 applicable regulations. Administration and support for
734 participating hospitals shall be provided by the Mississippi
735 Hospital Association.

736 (b) The division shall establish a Medicare Upper
737 Payment Limits Program, as defined in Section 1902(a)(30) of the
738 federal Social Security Act and any applicable federal
739 regulations, for hospitals, and may establish a Medicare Upper
740 Payments Limits Program for nursing facilities. The division
741 shall assess each hospital and, if the program is established for
742 nursing facilities, shall assess each nursing facility, for the
743 sole purpose of financing the state portion of the Medicare Upper



744 Payment Limits Program. This assessment shall be based on
745 Medicaid utilization, or other appropriate method consistent with
746 federal regulations, and will remain in effect as long as the
747 state participates in the Medicare Upper Payment Limits Program.
748 The division shall make additional reimbursement to hospitals and,
749 if the program is established for nursing facilities, shall make
750 additional reimbursement to nursing facilities, for the Medicare
751 Upper Payment Limits, as defined in Section 1902(a)(30) of the
752 federal Social Security Act and any applicable federal
753 regulations. This subparagraph (b) shall stand repealed from and
754 after July 1, 2005.

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

760 (19) (a) Perinatal risk management services. The
761 division shall promulgate regulations to be effective from and
762 after October 1, 1988, to establish a comprehensive perinatal
763 system for risk assessment of all pregnant and infant Medicaid
764 recipients and for management, education and follow-up for those
765 who are determined to be at risk. Services to be performed
766 include case management, nutrition assessment/counseling,
767 psychosocial assessment/counseling and health education. The
768 division shall set reimbursement rates for providers in
769 conjunction with the State Department of Health.

770 (b) Early intervention system services. The
771 division shall cooperate with the State Department of Health,
772 acting as lead agency, in the development and implementation of a
773 statewide system of delivery of early intervention services, under
774 Part C of the Individuals with Disabilities Education Act (IDEA).
775 The State Department of Health shall certify annually in writing
776 to the executive director of the division the dollar amount of



777 state early intervention funds available that will be utilized as
778 a certified match for Medicaid matching funds. Those funds then
779 shall be used to provide expanded targeted case management
780 services for Medicaid eligible children with special needs who are
781 eligible for the state's early intervention system.

782 Qualifications for persons providing service coordination shall be
783 determined by the State Department of Health and the Division of
784 Medicaid.

785 (20) Home- and community-based services for physically
786 disabled approved services as allowed by a waiver from the United
787 States Department of Health and Human Services for home- and
788 community-based services for physically disabled people using
789 state funds that are provided from the appropriation to the State
790 Department of Rehabilitation Services and used to match federal
791 funds under a cooperative agreement between the division and the
792 department, provided that funds for these services are
793 specifically appropriated to the Department of Rehabilitation
794 Services.

795 (21) Nurse practitioner services. Services furnished
796 by a registered nurse who is licensed and certified by the
797 Mississippi Board of Nursing as a nurse practitioner, including,
798 but not limited to, nurse anesthetists, nurse midwives, family
799 nurse practitioners, family planning nurse practitioners,
800 pediatric nurse practitioners, obstetrics-gynecology nurse
801 practitioners and neonatal nurse practitioners, under regulations
802 adopted by the division. Reimbursement for those services shall
803 not exceed ninety percent (90%) of the reimbursement rate for
804 comparable services rendered by a physician.

805 (22) Ambulatory services delivered in federally
806 qualified health centers, rural health centers and clinics of the
807 local health departments of the State Department of Health for
808 individuals eligible for Medicaid under this article based on
809 reasonable costs as determined by the division.



810 (23) Inpatient psychiatric services. Inpatient
811 psychiatric services to be determined by the division for
812 recipients under age twenty-one (21) that are provided under the
813 direction of a physician in an inpatient program in a licensed
814 acute care psychiatric facility or in a licensed psychiatric
815 residential treatment facility, before the recipient reaches age
816 twenty-one (21) or, if the recipient was receiving the services
817 immediately before he reached age twenty-one (21), before the
818 earlier of the date he no longer requires the services or the date
819 he reaches age twenty-two (22), as provided by federal
820 regulations. Precertification of inpatient days and residential
821 treatment days must be obtained as required by the division.

822 (24) [Deleted]

823 (25) [Deleted]

824 (26) Hospice care. As used in this paragraph, the term
825 "hospice care" means a coordinated program of active professional
826 medical attention within the home and outpatient and inpatient
827 care that treats the terminally ill patient and family as a unit,
828 employing a medically directed interdisciplinary team. The
829 program provides relief of severe pain or other physical symptoms
830 and supportive care to meet the special needs arising out of
831 physical, psychological, spiritual, social and economic stresses
832 that are experienced during the final stages of illness and during
833 dying and bereavement and meets the Medicare requirements for
834 participation as a hospice as provided in federal regulations.

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

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



842 (29) The Division of Medicaid may apply for a waiver
843 from the Department of Health and Human Services for home- and
844 community-based services for developmentally disabled people using
845 state funds that are provided from the appropriation to the State
846 Department of Mental Health and/or funds transferred to the
847 department by a political subdivision or instrumentality of the
848 state and used to match federal funds under a cooperative
849 agreement between the division and the department, provided that
850 funds for these services are specifically appropriated to the
851 Department of Mental Health and/or transferred to the department
852 by a political subdivision or instrumentality of the state.

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

855 (31) Targeted case management services for children
856 with special needs, under waivers from the United States
857 Department of Health and Human Services, using state funds that
858 are provided from the appropriation to the Mississippi Department
859 of Human Services and used to match federal funds under a
860 cooperative agreement between the division and the department.

861 (32) Care and services provided in Christian Science
862 Sanatoria listed and certified by the Commission for Accreditation
863 of Christian Science Nursing Organizations/Facilities, Inc.,
864 rendered in connection with treatment by prayer or spiritual means
865 to the extent that those services are subject to reimbursement
866 under Section 1903 of the Social Security Act.

867 (33) Podiatrist services.

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

872 (35) Services and activities authorized in Sections
873 43-27-101 and 43-27-103, using state funds that are provided from
874 the appropriation to the State Department of Human Services and



875 used to match federal funds under a cooperative agreement between
876 the division and the department.

877 (36) Nonemergency transportation services for
878 Medicaid-eligible persons, to be provided by the Division of
879 Medicaid. The division may contract with additional entities to
880 administer nonemergency transportation services as it deems
881 necessary. All providers shall have a valid driver's license,
882 vehicle inspection sticker, valid vehicle license tags and a
883 standard liability insurance policy covering the vehicle. The
884 division may pay providers a flat fee based on mileage tiers, or
885 in the alternative, may reimburse on actual miles traveled. The
886 division may apply to the Center for Medicare and Medicaid
887 Services (CMS) for a waiver to draw federal matching funds for
888 nonemergency transportation services as a covered service instead
889 of an administrative cost.

890 (37) [Deleted]

891 (38) Chiropractic services. A chiropractor's manual
892 manipulation of the spine to correct a subluxation, if x-ray
893 demonstrates that a subluxation exists and if the subluxation has
894 resulted in a neuromusculoskeletal condition for which
895 manipulation is appropriate treatment, and related spinal x-rays
896 performed to document these conditions. Reimbursement for
897 chiropractic services shall not exceed Seven Hundred Dollars
898 (\$700.00) per year per beneficiary.

899 (39) Dually eligible Medicare/Medicaid beneficiaries.
900 The division shall pay the Medicare deductible and * * *
901 coinsurance amounts for services available under Medicare, as
902 determined by the division.

903 (40) [Deleted]

904 (41) Services provided by the State Department of
905 Rehabilitation Services for the care and rehabilitation of persons
906 with spinal cord injuries or traumatic brain injuries, as allowed
907 under waivers from the United States Department of Health and



908 Human Services, using up to seventy-five percent (75%) of the
909 funds that are appropriated to the Department of Rehabilitation
910 Services from the Spinal Cord and Head Injury Trust Fund
911 established under Section 37-33-261 and used to match federal
912 funds under a cooperative agreement between the division and the
913 department.

914 (42) Notwithstanding any other provision in this
915 article to the contrary, the division may develop a population
916 health management program for women and children health services
917 through the age of one (1) year. This program is primarily for
918 obstetrical care associated with low birth weight and pre-term
919 babies. The division may apply to the federal Centers for
920 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
921 any other waivers that may enhance the program. In order to
922 effect cost savings, the division may develop a revised payment
923 methodology that may include at-risk capitated payments, and may
924 require member participation in accordance with the terms and
925 conditions of an approved federal waiver.

926 (43) The division shall provide reimbursement,
927 according to a payment schedule developed by the division, for
928 smoking cessation medications for pregnant women during their
929 pregnancy and other Medicaid-eligible women who are of
930 child-bearing age.

931 (44) Nursing facility services for the severely
932 disabled.

933 (a) Severe disabilities include, but are not
934 limited to, spinal cord injuries, closed head injuries and
935 ventilator dependent patients.

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



940 (45) Physician assistant services. Services furnished
941 by a physician assistant who is licensed by the State Board of
942 Medical Licensure and is practicing with physician supervision
943 under regulations adopted by the board, under regulations adopted
944 by the division. Reimbursement for those services shall not
945 exceed ninety percent (90%) of the reimbursement rate for
946 comparable services rendered by a physician.

947 (46) The division shall make application to the federal
948 Centers for Medicare and Medicaid Services (CMS) for a waiver to
949 develop and provide services for children with serious emotional
950 disturbances as defined in Section 43-14-1(1), which may include
951 home- and community-based services, case management services or
952 managed care services through mental health providers certified by
953 the Department of Mental Health. The division may implement and
954 provide services under this waived program only if funds for
955 these services are specifically appropriated for this purpose by
956 the Legislature, or if funds are voluntarily provided by affected
957 agencies.

958 (47) Notwithstanding any other provision in this
959 article to the contrary, the division, in conjunction with the
960 State Department of Health, shall develop and implement disease
961 management programs * * * for individuals with asthma, diabetes or
962 hypertension, including the use of grants, waivers, demonstrations
963 or other projects as necessary.

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

965 (a) Pediatric long-term acute care hospital
966 services means services provided to eligible persons under
967 twenty-one (21) years of age by a freestanding Medicare-certified
968 hospital that has an average length of inpatient stay greater than
969 twenty-five (25) days and that is primarily engaged in providing
970 chronic or long-term medical care to persons under twenty-one (21)
971 years of age.



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

974 (49) The division shall establish copayments for all
975 Medicaid services for which copayments are allowable under federal
976 law or regulation, except for nonemergency transportation
977 services, and shall set the amount of the copayment for each of
978 those services at the maximum amount allowable under federal law
979 or regulation.

980 Notwithstanding any other provision of this article to the
981 contrary, the division shall reduce the rate of reimbursement to
982 providers for any service provided under this section by five
983 percent (5%) of the allowed amount for that service. However, the
984 reduction in the reimbursement rates required by this paragraph
985 shall not apply to inpatient hospital services, nursing facility
986 services, intermediate care facility services, psychiatric
987 residential treatment facility services, pharmacy services
988 provided under paragraph (9) of this section, or any service
989 provided by the University of Mississippi Medical Center or a
990 state agency, a state facility or a public agency that either
991 provides its own state match through intergovernmental transfer or
992 certification of funds to the division, or a service for which the
993 federal government sets the reimbursement methodology and rate.
994 In addition, the reduction in the reimbursement rates required by
995 this paragraph shall not apply to case management services * * *
996 provided under the home- and community-based services program for
997 the elderly and disabled by a planning and development district
998 (PDD). Planning and development districts participating in the
999 home- and community-based services program for the elderly and
1000 disabled as case management providers shall be reimbursed for case
1001 management services at the maximum rate approved by the Centers
1002 for Medicare and Medicaid Services (CMS). PDDs shall transfer to
1003 the division state match from public funds (not federal) in an
1004 amount equal to the difference between the maximum case management



1005 reimbursement rate approved by CMS and a five percent (5%)
1006 reduction in that rate. The division shall invoice each PDD
1007 fifteen (15) days after the end of each quarter for said
1008 intergovernmental transfer based on the number of Medicaid home-
1009 and community-based clients the PDD served during the quarter.

1010 The division may remove the five percent (5%) reduction in
1011 reimbursement for those providers who participate in the
1012 division's emergency room redirection program and achieve the
1013 performance measures and reduction of costs required of that
1014 program.

1015 Notwithstanding any provision of this article, except as
1016 authorized in the following paragraph and in Section 43-13-139,
1017 neither (a) the limitations on quantity or frequency of use of or
1018 the fees or charges for any of the care or services available to
1019 recipients under this section, nor (b) the payments or rates of
1020 reimbursement to providers rendering care or services authorized
1021 under this section to recipients, may be increased, decreased or
1022 otherwise changed from the levels in effect on July 1, 1999,
1023 unless they are authorized by an amendment to this section by the
1024 Legislature. However, the restriction in this paragraph shall not
1025 prevent the division from changing the payments or rates of
1026 reimbursement to providers without an amendment to this section
1027 whenever those changes are required by federal law or regulation,
1028 or whenever those changes are necessary to correct administrative
1029 errors or omissions in calculating those payments or rates of
1030 reimbursement.

1031 Notwithstanding any provision of this article, no new groups
1032 or categories of recipients and new types of care and services may
1033 be added without enabling legislation from the Mississippi
1034 Legislature, except that the division may authorize those changes
1035 without enabling legislation when the addition of recipients or
1036 services is ordered by a court of proper authority. The executive
1037 director shall keep the Governor advised on a timely basis of the



1038 funds available for expenditure and the projected expenditures.
1039 If current or projected expenditures of the division can be
1040 reasonably anticipated to exceed the amounts appropriated for any
1041 fiscal year, the Governor, after consultation with the executive
1042 director, shall discontinue any or all of the payment of the types
1043 of care and services as provided in this section that are deemed
1044 to be optional services under Title XIX of the federal Social
1045 Security Act, as amended, for any period necessary to not exceed
1046 appropriated funds, and when necessary shall institute any other
1047 cost containment measures on any program or programs authorized
1048 under the article to the extent allowed under the federal law
1049 governing that program or programs, it being the intent of the
1050 Legislature that expenditures during any fiscal year shall not
1051 exceed the amounts appropriated for that fiscal year.

1052 Notwithstanding any other provision of this article, it shall
1053 be the duty of each nursing facility, intermediate care facility
1054 for the mentally retarded, psychiatric residential treatment
1055 facility, and nursing facility for the severely disabled that is
1056 participating in the Medicaid program to keep and maintain books,
1057 documents and other records as prescribed by the Division of
1058 Medicaid in substantiation of its cost reports for a period of
1059 three (3) years after the date of submission to the Division of
1060 Medicaid of an original cost report, or three (3) years after the
1061 date of submission to the Division of Medicaid of an amended cost
1062 report.

1063 This section shall stand repealed on July 1, 2004.

1064 **SECTION 4.** Section 43-13-107, Mississippi Code of 1972, is
1065 amended as follows:

1066 43-13-107. (1) The Division of Medicaid is created in the
1067 Office of the Governor and established to administer this article
1068 and perform such other duties as are prescribed by law.

1069 (2) (a) The Governor shall appoint a full-time executive
1070 director, with the advice and consent of the Senate, who shall be



1071 either (i) a physician with administrative experience in a medical
1072 care or health program, or (ii) a person holding a graduate degree
1073 in medical care administration, public health, hospital
1074 administration, or the equivalent, or (iii) a person holding a
1075 bachelor's degree in business administration or hospital
1076 administration, with at least ten (10) years' experience in
1077 management-level administration of Medicaid programs, and who
1078 shall serve at the will and pleasure of the Governor. The
1079 executive director shall be the official secretary and legal
1080 custodian of the records of the division; shall be the agent of
1081 the division for the purpose of receiving all service of process,
1082 summons and notices directed to the division; and shall perform
1083 such other duties as the Governor may prescribe from time to time.

1084 (b) The executive director, with the approval of the
1085 Governor and subject to the rules and regulations of the State
1086 Personnel Board, shall employ such professional, administrative,
1087 stenographic, secretarial, clerical and technical assistance as
1088 may be necessary to perform the duties required in administering
1089 this article and fix the compensation therefor, all in accordance
1090 with a state merit system meeting federal requirements when the
1091 salary of the executive director is not set by law, that salary
1092 shall be set by the State Personnel Board. No employees of the
1093 Division of Medicaid shall be considered to be staff members of
1094 the immediate Office of the Governor; however, the provisions of
1095 Section 25-9-107(c) (xv) shall apply to the executive director and
1096 other administrative heads of the division.

1097 (3) (a) There is established a Medical Care Advisory
1098 Committee, which shall be the committee that is required by
1099 federal regulation to advise the Division of Medicaid about health
1100 and medical care services.

1101 (b) The advisory committee shall consist of not less
1102 than eleven (11) members, as follows:



1103 (i) The Governor shall appoint five (5) members,
1104 one (1) from each congressional district as presently constituted;

1105 (ii) The Lieutenant Governor shall appoint three
1106 (3) members, one (1) from each Supreme Court district;

1107 (iii) The Speaker of the House of Representatives
1108 shall appoint three (3) members, one (1) from each Supreme Court
1109 district.

1110 All members appointed under this paragraph shall either be
1111 health care providers or consumers of health care services. One
1112 (1) member appointed by each of the appointing authorities shall
1113 be a board certified physician.

1114 (c) The respective chairmen of the House Public Health
1115 and Welfare Committee, the House Appropriations Committee, the
1116 Senate Public Health and Welfare Committee and the Senate
1117 Appropriations Committee, or their designees, one (1) member of
1118 the State Senate appointed by the Lieutenant Governor and one (1)
1119 member of the House of Representatives appointed by the Speaker of
1120 the House, shall serve as ex officio nonvoting members of the
1121 advisory committee.

1122 (d) In addition to the committee members required by
1123 paragraph (b), the advisory committee shall consist of such other
1124 members as are necessary to meet the requirements of the federal
1125 regulation applicable to the advisory committee, who shall be
1126 appointed as provided in the federal regulation.

1127 (e) The chairmanship of the advisory committee shall
1128 alternate for twelve-month periods between the chairmen of the
1129 House and Senate Public Health and Welfare Committees, with the
1130 Chairman of the House Public Health and Welfare Committee serving
1131 as the first chairman.

1132 (f) The members of the advisory committee specified in
1133 paragraph (b) shall serve for terms that are concurrent with the
1134 terms of members of the Legislature, and any member appointed
1135 under paragraph (b) may be reappointed to the advisory committee.



1136 The members of the advisory committee specified in paragraph (b)
1137 shall serve without compensation, but shall receive reimbursement
1138 to defray actual expenses incurred in the performance of committee
1139 business as authorized by law. Legislators shall receive per diem
1140 and expenses which may be paid from the contingent expense funds
1141 of their respective houses in the same amounts as provided for
1142 committee meetings when the Legislature is not in session.

1143 (g) The advisory committee shall meet not less than
1144 quarterly, and advisory committee members shall be furnished
1145 written notice of the meetings at least ten (10) days before the
1146 date of the meeting.

1147 (h) The executive director shall submit to the advisory
1148 committee all amendments, modifications and changes to the state
1149 plan for the operation of the Medicaid program, for review by the
1150 advisory committee before the amendments, modifications or changes
1151 may be implemented by the division.

1152 (i) The advisory committee, among its duties and
1153 responsibilities, shall:

1154 (i) Advise the division with respect to
1155 amendments, modifications and changes to the state plan for the
1156 operation of the Medicaid program;

1157 (ii) Advise the division with respect to issues
1158 concerning receipt and disbursement of funds and eligibility for
1159 Medicaid;

1160 (iii) Advise the division with respect to
1161 determining the quantity, quality and extent of medical care
1162 provided under this article;

1163 (iv) Communicate the views of the medical care
1164 professions to the division and communicate the views of the
1165 division to the medical care professions;

1166 (v) Gather information on reasons that medical
1167 care providers do not participate in the Medicaid program and
1168 changes that could be made in the program to encourage more



1169 providers to participate in the Medicaid program, and advise the
1170 division with respect to encouraging physicians and other medical
1171 care providers to participate in the Medicaid program;

1172 (vi) Provide a written report on or before
1173 November 30 of each year to the Governor, Lieutenant Governor and
1174 Speaker of the House of Representatives.

1175 (4) (a) There is established a Drug Use Review Board, which
1176 shall be the board that is required by federal law to:

1177 (i) Review and initiate retrospective drug use,
1178 review including ongoing periodic examination of claims data and
1179 other records in order to identify patterns of fraud, abuse, gross
1180 overuse, or inappropriate or medically unnecessary care, among
1181 physicians, pharmacists and individuals receiving Medicaid
1182 benefits or associated with specific drugs or groups of drugs.

1183 (ii) Review and initiate ongoing interventions for
1184 physicians and pharmacists, targeted toward therapy problems or
1185 individuals identified in the course of retrospective drug use
1186 reviews.

1187 (iii) On an ongoing basis, assess data on drug use
1188 against explicit predetermined standards using the compendia and
1189 literature set forth in federal law and regulations.

1190 (b) The board shall consist of not less than twelve
1191 (12) members appointed by the Governor or his designee.

1192 (c) The board shall meet at least quarterly, and board
1193 members shall be furnished written notice of the meetings at least
1194 ten (10) days before the date of the meeting.

1195 (d) The board meetings shall be open to the public,
1196 members of the press, legislators and consumers. Additionally,
1197 all documents provided to board members shall be available to
1198 members of the Legislature in the same manner, and shall be made
1199 available to others for a reasonable fee for copying. However,
1200 patient confidentiality and provider confidentiality shall be
1201 protected by blinding patient names and provider names with



1202 numerical or other anonymous identifiers. The board meetings
1203 shall be subject to the Open Meetings Act (Section 25-41-1 et
1204 seq.). Board meetings conducted in violation of this section
1205 shall be deemed unlawful.

1206 (5) (a) There is established a Pharmacy and Therapeutics
1207 Committee, which shall be appointed by the Governor or his
1208 designee.

1209 (b) The committee shall meet at least quarterly, and
1210 committee members shall be furnished written notice of the
1211 meetings at least ten (10) days before the date of the meeting.

1212 (c) The committee meetings shall be open to the public,
1213 members of the press, legislators and consumers. Additionally,
1214 all documents provided to committee members shall be available to
1215 members of the Legislature in the same manner, and shall be made
1216 available to others for a reasonable fee for copying. However,
1217 patient confidentiality and provider confidentiality shall be
1218 protected by blinding patient names and provider names with
1219 numerical or other anonymous identifiers. The committee meetings
1220 shall be subject to the Open Meetings Act (Section 25-41-1 et
1221 seq.). Committee meetings conducted in violation of this section
1222 shall be deemed unlawful.

1223 (d) After a thirty-day public notice, the executive
1224 director or his or her designee shall present the division's
1225 recommendation regarding prior approval for a therapeutic class of
1226 drugs to the committee. However, in circumstances where the
1227 division deems it necessary for the health and safety of Medicaid
1228 beneficiaries, the division may present to the committee its
1229 recommendations regarding a particular drug without a thirty-day
1230 public notice. In making such presentation, the division shall
1231 state to the committee the circumstances which precipitate the
1232 need for the committee to review the status of a particular drug
1233 without a thirty-day public notice. The committee may determine
1234 whether or not to review the particular drug under the



1235 circumstances stated by the division without a thirty-day public
1236 notice. If the committee determines to review the status of the
1237 particular drug, it shall make its recommendations to the
1238 division, after which the division shall file such recommendations
1239 for a thirty-day public comment under the provisions of Section
1240 25-43-7(1), Mississippi Code of 1972.

1241 (e) Upon reviewing the information and recommendations,
1242 the committee shall forward a written recommendation approved by a
1243 majority of the committee to the executive director or his or her
1244 designee. The decisions of the committee regarding any
1245 limitations to be imposed on any drug or its use for a specified
1246 indication shall be based on sound clinical evidence found in
1247 labeling, drug compendia, and peer reviewed clinical literature
1248 pertaining to use of the drug in the relevant population.

1249 (f) Upon reviewing and considering all recommendations
1250 including recommendation of the committee, comments, and data, the
1251 executive director shall make a final determination whether to
1252 require prior approval of a therapeutic class of drugs, or modify
1253 existing prior approval requirements for a therapeutic class of
1254 drugs.

1255 (g) At least thirty (30) days before the executive
1256 director implements new or amended prior authorization decisions,
1257 written notice of the executive director's decision shall be
1258 provided to all prescribing Medicaid providers, all Medicaid
1259 enrolled pharmacies, and any other party who has requested the
1260 notification. However, notice given under Section 25-43-7(1) will
1261 substitute for and meet the requirement for notice under this
1262 subsection.

1263 (6) This section shall stand repealed on July 1, 2004.

1264 **SECTION 5.** Section 43-13-122, Mississippi Code of 1972, is
1265 amended as follows:

1266 43-13-122. (1) The division is authorize to apply to the
1267 Center for Medicare and Medicaid Services of the United States



1268 Department of Health and Human Services for waivers and research
1269 and demonstration grants * * *.

1270 (2) The division is further authorized to accept and expend
1271 any grants, donations or contributions from any public or private
1272 organization together with any additional federal matching funds
1273 that may accrue and including, but not limited to, one hundred
1274 percent (100%) federal grant funds or funds from any governmental
1275 entity or instrumentality thereof in furthering the purposes and
1276 objectives of the Mississippi Medicaid program, provided that such
1277 receipts and expenditures are reported and otherwise handled in
1278 accordance with the General Fund Stabilization Act. The
1279 Department of Finance and Administration is authorized to transfer
1280 monies to the division from special funds in the State Treasury in
1281 amounts not exceeding the amounts authorized in the appropriation
1282 to the division.

1283 **SECTION 6.** Section 43-13-145, Mississippi Code of 1972, is
1284 amended as follows:

1285 43-13-145. (1) (a) Upon each nursing facility and each
1286 intermediate care facility for the mentally retarded licensed by
1287 the State of Mississippi, there is levied an assessment in the
1288 amount of Four Dollars (\$4.00) per day for each licensed and/or
1289 certified bed of the facility. The division may apply for a
1290 waiver from the United States Secretary of Health and Human
1291 Services to exempt nonprofit, public, charitable or religious
1292 facilities from the assessment levied under this subsection, and
1293 if a waiver is granted, those facilities shall be exempt from any
1294 assessment levied under this subsection after the date that the
1295 division receives notice that the waiver has been granted.

1296 (b) A nursing facility or intermediate care facility
1297 for the mentally retarded is exempt from the assessment levied
1298 under this subsection if the facility is operated under the
1299 direction and control of:



1300 (i) The United States Veterans Administration or
1301 other agency or department of the United States government;

1302 (ii) The State Veterans Affairs Board;

1303 (iii) The University of Mississippi Medical
1304 Center; or

1305 (iv) A state agency or a state facility that
1306 either provides its own state match through intergovernmental
1307 transfer or certification of funds to the division.

1308 (2) (a) Upon each psychiatric residential treatment
1309 facility licensed by the State of Mississippi, there is levied an
1310 assessment in the amount of Three Dollars (\$3.00) per day for each
1311 licensed and/or certified bed of the facility.

1312 (b) A psychiatric residential treatment facility is
1313 exempt from the assessment levied under this subsection if the
1314 facility is operated under the direction and control of:

1315 (i) The United States Veterans Administration or
1316 other agency or department of the United States government;

1317 (ii) The University of Mississippi Medical Center;

1318 (iii) A state agency or a state facility that
1319 either provides its own state match through intergovernmental
1320 transfer or certification of funds to the division.

1321 (3) (a) Upon each hospital licensed by the State of
1322 Mississippi, there is levied an assessment in the amount of One
1323 Dollar and Fifty Cents (\$1.50) per day for each licensed inpatient
1324 acute care bed of the hospital.

1325 (b) A hospital is exempt from the assessment levied
1326 under this subsection if the hospital is operated under the
1327 direction and control of:

1328 (i) The United States Veterans Administration or
1329 other agency or department of the United States government;

1330 (ii) The University of Mississippi Medical Center;

1331 or



1332 (iii) A state agency or a state facility that
1333 either provides its own state match through intergovernmental
1334 transfer or certification of funds to the division.

1335 (4) Each health care facility that is subject to the
1336 provisions of this section shall keep and preserve such suitable
1337 books and records as may be necessary to determine the amount of
1338 assessment for which it is liable under this section. The books
1339 and records shall be kept and preserved for a period of not less
1340 than five (5) years, and those books and records shall be open for
1341 examination during business hours by the division, the State Tax
1342 Commission, the Office of the Attorney General and the State
1343 Department of Health.

1344 (5) The assessment levied under this section shall be
1345 collected by the division each month beginning on April 12, 2002.

1346 (6) All assessments collected under this section shall be
1347 deposited in the Medical Care Fund created by Section 43-13-143.

1348 (7) The assessment levied under this section shall be in
1349 addition to any other assessments, taxes or fees levied by law,
1350 and the assessment shall constitute a debt due the State of
1351 Mississippi from the time the assessment is due until it is paid.

1352 (8) (a) If a health care facility that is liable for
1353 payment of the assessment levied under this section does not pay
1354 the assessment when it is due, the division shall give written
1355 notice to the health care facility by certified or registered mail
1356 demanding payment of the assessment within ten (10) days from the
1357 date of delivery of the notice. If the health care facility
1358 fails or refuses to pay the assessment after receiving the notice
1359 and demand from the division, the division shall withhold from any
1360 Medicaid reimbursement payments that are due to the health care
1361 facility the amount of the unpaid assessment and a penalty of ten
1362 percent (10%) of the amount of the assessment, plus the legal rate
1363 of interest until the assessment is paid in full. If the health
1364 care facility does not participate in the Medicaid program, the



1365 division shall turn over to the Office of the Attorney General the
1366 collection of the unpaid assessment by civil action. In any such
1367 civil action, the Office of the Attorney General shall collect the
1368 amount of the unpaid assessment and a penalty of ten percent (10%)
1369 of the amount of the assessment, plus the legal rate of interest
1370 until the assessment is paid in full.

1371 (b) As an additional or alternative method for
1372 collecting unpaid assessments under this section, if a health care
1373 facility fails or refuses to pay the assessment after receiving
1374 notice and demand from the division, the division may file a
1375 notice of a tax lien with the circuit clerk of the county in which
1376 the health care facility is located, for the amount of the unpaid
1377 assessment and a penalty of ten percent (10%) of the amount of the
1378 assessment, plus the legal rate of interest until the assessment
1379 is paid in full. Immediately upon receipt of notice of the tax
1380 lien for the assessment, the circuit clerk shall enter the notice
1381 of the tax lien as a judgment upon the judgment roll and show in
1382 the appropriate columns the name of the health care facility as
1383 judgment debtor, the name of the division as judgment creditor,
1384 the amount of the unpaid assessment, and the date and time or
1385 enrollment. The judgment shall be valid as against mortgagees,
1386 pledgees, entrusters, purchasers, judgment creditors and other
1387 persons from the time of filing with the clerk. The amount of the
1388 judgment shall be a debt due the State of Mississippi and remain a
1389 lien upon the tangible property of the health care facility until
1390 the judgment is satisfied. The judgment shall be the equivalent
1391 of any enrolled judgment of a court of record and shall serve as
1392 authority for the issuance of writs of execution, writs of
1393 attachment or other remedial writs.

1394 **SECTION 7.** Section 41-7-191, Mississippi Code of 1972, is
1395 amended as follows:



1396 41-7-191. (1) No person shall engage in any of the
1397 following activities without obtaining the required certificate of
1398 need:

1399 (a) The construction, development or other
1400 establishment of a new health care facility;

1401 (b) The relocation of a health care facility or portion
1402 thereof, or major medical equipment, unless such relocation of a
1403 health care facility or portion thereof, or major medical
1404 equipment, which does not involve a capital expenditure by or on
1405 behalf of a health care facility, is within five thousand two
1406 hundred eighty (5,280) feet from the main entrance of the health
1407 care facility;

1408 (c) Any change in the existing bed complement of any
1409 health care facility through the addition or conversion of any
1410 beds or the alteration, modernizing or refurbishing of any unit or
1411 department in which the beds may be located;

1412 (d) Offering of the following health services if those
1413 services have not been provided on a regular basis by the proposed
1414 provider of such services within the period of twelve (12) months
1415 prior to the time such services would be offered:

1416 (i) Open heart surgery services;

1417 (ii) Cardiac catheterization services;

1418 (iii) Comprehensive inpatient rehabilitation
1419 services;

1420 (iv) Licensed psychiatric services;

1421 (v) Licensed chemical dependency services;

1422 (vi) Radiation therapy services;

1423 (vii) Diagnostic imaging services of an invasive
1424 nature, i.e. invasive digital angiography;

1425 (viii) Nursing home care as defined in
1426 subparagraphs (iv), (vi) and (viii) of Section 41-7-173(h);

1427 (ix) Home health services;

1428 (x) Swing-bed services;



1429 (xi) Ambulatory surgical services;
1430 (xii) Magnetic resonance imaging services;
1431 (xiii) Extracorporeal shock wave lithotripsy
1432 services;
1433 (xiv) Long-term care hospital services;
1434 (xv) Positron Emission Tomography (PET) services;
1435 (e) The relocation of one or more health services from
1436 one physical facility or site to another physical facility or
1437 site, unless such relocation, which does not involve a capital
1438 expenditure by or on behalf of a health care facility, (i) is to a
1439 physical facility or site within one thousand three hundred twenty
1440 (1,320) feet from the main entrance of the health care facility
1441 where the health care service is located, or (ii) is the result of
1442 an order of a court of appropriate jurisdiction or a result of
1443 pending litigation in such court, or by order of the State
1444 Department of Health, or by order of any other agency or legal
1445 entity of the state, the federal government, or any political
1446 subdivision of either, whose order is also approved by the State
1447 Department of Health;
1448 (f) The acquisition or otherwise control of any major
1449 medical equipment for the provision of medical services; provided,
1450 however, (i) the acquisition of any major medical equipment used
1451 only for research purposes, and (ii) the acquisition of major
1452 medical equipment to replace medical equipment for which a
1453 facility is already providing medical services and for which the
1454 State Department of Health has been notified before the date of
1455 such acquisition shall be exempt from this paragraph; an
1456 acquisition for less than fair market value must be reviewed, if
1457 the acquisition at fair market value would be subject to review;
1458 (g) Changes of ownership of existing health care
1459 facilities in which a notice of intent is not filed with the State
1460 Department of Health at least thirty (30) days prior to the date
1461 such change of ownership occurs, or a change in services or bed



1462 capacity as prescribed in paragraph (c) or (d) of this subsection
1463 as a result of the change of ownership; an acquisition for less
1464 than fair market value must be reviewed, if the acquisition at
1465 fair market value would be subject to review;

1466 (h) The change of ownership of any health care facility
1467 defined in subparagraphs (iv), (vi) and (viii) of Section
1468 41-7-173(h), in which a notice of intent as described in paragraph
1469 (g) has not been filed and if the Executive Director, Division of
1470 Medicaid, Office of the Governor, has not certified in writing
1471 that there will be no increase in allowable costs to Medicaid from
1472 revaluation of the assets or from increased interest and
1473 depreciation as a result of the proposed change of ownership;

1474 (i) Any activity described in paragraphs (a) through
1475 (h) if undertaken by any person if that same activity would
1476 require certificate of need approval if undertaken by a health
1477 care facility;

1478 (j) Any capital expenditure or deferred capital
1479 expenditure by or on behalf of a health care facility not covered
1480 by paragraphs (a) through (h);

1481 (k) The contracting of a health care facility as
1482 defined in subparagraphs (i) through (viii) of Section 41-7-173(h)
1483 to establish a home office, subunit, or branch office in the space
1484 operated as a health care facility through a formal arrangement
1485 with an existing health care facility as defined in subparagraph
1486 (ix) of Section 41-7-173(h).

1487 (2) From and after the effective date of Senate Bill No.
1488 2346 (2003 Regular Session), the State Department of Health shall
1489 not issue a certificate of need to any person for the new
1490 construction of, addition to, expansion of or conversion to any
1491 skilled or intermediate care nursing facility beds or services.
1492 Provided, that this prohibition shall not apply to any certificate
1493 of need pending before the department but not issued due to either
1494 an administrative or judicial appeal. Prior to the effective date



1495 of Senate Bill No. 2346 (2003 Regular Session) the State
1496 Department of Health shall not grant approval for or issue a
1497 certificate of need to any person proposing the new construction
1498 of, addition to, or expansion of any health care facility defined
1499 in subparagraphs (iv) (skilled nursing facility) and (vi)
1500 (intermediate care facility) of Section 41-7-173(h) or the
1501 conversion of vacant hospital beds to provide skilled or
1502 intermediate nursing home care, except as hereinafter authorized:

1503 (a) The department may issue a certificate of need to
1504 any person proposing the new construction of any health care
1505 facility defined in subparagraphs (iv) and (vi) of Section
1506 41-7-173(h) as part of a life care retirement facility, in any
1507 county bordering on the Gulf of Mexico in which is located a
1508 National Aeronautics and Space Administration facility, not to
1509 exceed forty (40) beds. From and after July 1, 1999, there shall
1510 be no prohibition or restrictions on participation in the Medicaid
1511 program (Section 43-13-101 et seq.) for the beds in the health
1512 care facility that were authorized under this paragraph (a).

1513 (b) The department may issue certificates of need in
1514 Harrison County to provide skilled nursing home care for
1515 Alzheimer's disease patients and other patients, not to exceed one
1516 hundred fifty (150) beds. From and after July 1, 1999, there
1517 shall be no prohibition or restrictions on participation in the
1518 Medicaid program (Section 43-13-101 et seq.) for the beds in the
1519 nursing facilities that were authorized under this paragraph (b).

1520 (c) The department may issue a certificate of need for
1521 the addition to or expansion of any skilled nursing facility that
1522 is part of an existing continuing care retirement community
1523 located in Madison County, provided that the recipient of the
1524 certificate of need agrees in writing that the skilled nursing
1525 facility will not at any time participate in the Medicaid program
1526 (Section 43-13-101 et seq.) or admit or keep any patients in the
1527 skilled nursing facility who are participating in the Medicaid



1528 program. This written agreement by the recipient of the
1529 certificate of need shall be fully binding on any subsequent owner
1530 of the skilled nursing facility, if the ownership of the facility
1531 is transferred at any time after the issuance of the certificate
1532 of need. Agreement that the skilled nursing facility will not
1533 participate in the Medicaid program shall be a condition of the
1534 issuance of a certificate of need to any person under this
1535 paragraph (c), and if such skilled nursing facility at any time
1536 after the issuance of the certificate of need, regardless of the
1537 ownership of the facility, participates in the Medicaid program or
1538 admits or keeps any patients in the facility who are participating
1539 in the Medicaid program, the State Department of Health shall
1540 revoke the certificate of need, if it is still outstanding, and
1541 shall deny or revoke the license of the skilled nursing facility,
1542 at the time that the department determines, after a hearing
1543 complying with due process, that the facility has failed to comply
1544 with any of the conditions upon which the certificate of need was
1545 issued, as provided in this paragraph and in the written agreement
1546 by the recipient of the certificate of need. The total number of
1547 beds that may be authorized under the authority of this paragraph
1548 (c) shall not exceed sixty (60) beds.

1549 (d) The State Department of Health may issue a
1550 certificate of need to any hospital located in DeSoto County for
1551 the new construction of a skilled nursing facility, not to exceed
1552 one hundred twenty (120) beds, in DeSoto County. From and after
1553 July 1, 1999, there shall be no prohibition or restrictions on
1554 participation in the Medicaid program (Section 43-13-101 et seq.)
1555 for the beds in the nursing facility that were authorized under
1556 this paragraph (d).

1557 (e) The State Department of Health may issue a
1558 certificate of need for the construction of a nursing facility or
1559 the conversion of beds to nursing facility beds at a personal care
1560 facility for the elderly in Lowndes County that is owned and



1561 operated by a Mississippi nonprofit corporation, not to exceed
1562 sixty (60) beds. From and after July 1, 1999, there shall be no
1563 prohibition or restrictions on participation in the Medicaid
1564 program (Section 43-13-101 et seq.) for the beds in the nursing
1565 facility that were authorized under this paragraph (e).

1566 (f) The State Department of Health may issue a
1567 certificate of need for conversion of a county hospital facility
1568 in Itawamba County to a nursing facility, not to exceed sixty (60)
1569 beds, including any necessary construction, renovation or
1570 expansion. From and after July 1, 1999, there shall be no
1571 prohibition or restrictions on participation in the Medicaid
1572 program (Section 43-13-101 et seq.) for the beds in the nursing
1573 facility that were authorized under this paragraph (f).

1574 (g) The State Department of Health may issue a
1575 certificate of need for the construction or expansion of nursing
1576 facility beds or the conversion of other beds to nursing facility
1577 beds in either Hinds, Madison or Rankin County, not to exceed
1578 sixty (60) beds. From and after July 1, 1999, there shall be no
1579 prohibition or restrictions on participation in the Medicaid
1580 program (Section 43-13-101 et seq.) for the beds in the nursing
1581 facility that were authorized under this paragraph (g).

1582 (h) The State Department of Health may issue a
1583 certificate of need for the construction or expansion of nursing
1584 facility beds or the conversion of other beds to nursing facility
1585 beds in either Hancock, Harrison or Jackson County, not to exceed
1586 sixty (60) beds. From and after July 1, 1999, there shall be no
1587 prohibition or restrictions on participation in the Medicaid
1588 program (Section 43-13-101 et seq.) for the beds in the facility
1589 that were authorized under this paragraph (h).

1590 (i) The department may issue a certificate of need for
1591 the new construction of a skilled nursing facility in Leake
1592 County, provided that the recipient of the certificate of need
1593 agrees in writing that the skilled nursing facility will not at



1594 any time participate in the Medicaid program (Section 43-13-101 et
1595 seq.) or admit or keep any patients in the skilled nursing
1596 facility who are participating in the Medicaid program. This
1597 written agreement by the recipient of the certificate of need
1598 shall be fully binding on any subsequent owner of the skilled
1599 nursing facility, if the ownership of the facility is transferred
1600 at any time after the issuance of the certificate of need.
1601 Agreement that the skilled nursing facility will not participate
1602 in the Medicaid program shall be a condition of the issuance of a
1603 certificate of need to any person under this paragraph (i), and if
1604 such skilled nursing facility at any time after the issuance of
1605 the certificate of need, regardless of the ownership of the
1606 facility, participates in the Medicaid program or admits or keeps
1607 any patients in the facility who are participating in the Medicaid
1608 program, the State Department of Health shall revoke the
1609 certificate of need, if it is still outstanding, and shall deny or
1610 revoke the license of the skilled nursing facility, at the time
1611 that the department determines, after a hearing complying with due
1612 process, that the facility has failed to comply with any of the
1613 conditions upon which the certificate of need was issued, as
1614 provided in this paragraph and in the written agreement by the
1615 recipient of the certificate of need. The provision of Section
1616 43-7-193(1) regarding substantial compliance of the projection of
1617 need as reported in the current State Health Plan is waived for
1618 the purposes of this paragraph. The total number of nursing
1619 facility beds that may be authorized by any certificate of need
1620 issued under this paragraph (i) shall not exceed sixty (60) beds.
1621 If the skilled nursing facility authorized by the certificate of
1622 need issued under this paragraph is not constructed and fully
1623 operational within eighteen (18) months after July 1, 1994, the
1624 State Department of Health, after a hearing complying with due
1625 process, shall revoke the certificate of need, if it is still
1626 outstanding, and shall not issue a license for the skilled nursing



1627 facility at any time after the expiration of the eighteen-month
1628 period.

1629 (j) The department may issue certificates of need to
1630 allow any existing freestanding long-term care facility in
1631 Tishomingo County and Hancock County that on July 1, 1995, is
1632 licensed with fewer than sixty (60) beds. For the purposes of
1633 this paragraph (j), the provision of Section 41-7-193(1) requiring
1634 substantial compliance with the projection of need as reported in
1635 the current State Health Plan is waived. From and after July 1,
1636 1999, there shall be no prohibition or restrictions on
1637 participation in the Medicaid program (Section 43-13-101 et seq.)
1638 for the beds in the long-term care facilities that were authorized
1639 under this paragraph (j).

1640 (k) The department may issue a certificate of need for
1641 the construction of a nursing facility at a continuing care
1642 retirement community in Lowndes County. The total number of beds
1643 that may be authorized under the authority of this paragraph (k)
1644 shall not exceed sixty (60) beds. From and after July 1, 2001,
1645 the prohibition on the facility participating in the Medicaid
1646 program (Section 43-13-101 et seq.) that was a condition of
1647 issuance of the certificate of need under this paragraph (k) shall
1648 be revised as follows: The nursing facility may participate in
1649 the Medicaid program from and after July 1, 2001, if the owner of
1650 the facility on July 1, 2001, agrees in writing that no more than
1651 thirty (30) of the beds at the facility will be certified for
1652 participation in the Medicaid program, and that no claim will be
1653 submitted for Medicaid reimbursement for more than thirty (30)
1654 patients in the facility in any month or for any patient in the
1655 facility who is in a bed that is not Medicaid-certified. This
1656 written agreement by the owner of the facility shall be a
1657 condition of licensure of the facility, and the agreement shall be
1658 fully binding on any subsequent owner of the facility if the
1659 ownership of the facility is transferred at any time after July 1,



1660 2001. After this written agreement is executed, the Division of
1661 Medicaid and the State Department of Health shall not certify more
1662 than thirty (30) of the beds in the facility for participation in
1663 the Medicaid program. If the facility violates the terms of the
1664 written agreement by admitting or keeping in the facility on a
1665 regular or continuing basis more than thirty (30) patients who are
1666 participating in the Medicaid program, the State Department of
1667 Health shall revoke the license of the facility, at the time that
1668 the department determines, after a hearing complying with due
1669 process, that the facility has violated the written agreement.

1670 (1) Provided that funds are specifically appropriated
1671 therefor by the Legislature, the department may issue a
1672 certificate of need to a rehabilitation hospital in Hinds County
1673 for the construction of a sixty-bed long-term care nursing
1674 facility dedicated to the care and treatment of persons with
1675 severe disabilities including persons with spinal cord and
1676 closed-head injuries and ventilator-dependent patients. The
1677 provision of Section 41-7-193(1) regarding substantial compliance
1678 with projection of need as reported in the current State Health
1679 Plan is hereby waived for the purpose of this paragraph.

1680 (m) The State Department of Health may issue a
1681 certificate of need to a county-owned hospital in the Second
1682 Judicial District of Panola County for the conversion of not more
1683 than seventy-two (72) hospital beds to nursing facility beds,
1684 provided that the recipient of the certificate of need agrees in
1685 writing that none of the beds at the nursing facility will be
1686 certified for participation in the Medicaid program (Section
1687 43-13-101 et seq.), and that no claim will be submitted for
1688 Medicaid reimbursement in the nursing facility in any day or for
1689 any patient in the nursing facility. This written agreement by
1690 the recipient of the certificate of need shall be a condition of
1691 the issuance of the certificate of need under this paragraph, and
1692 the agreement shall be fully binding on any subsequent owner of



1693 the nursing facility if the ownership of the nursing facility is
1694 transferred at any time after the issuance of the certificate of
1695 need. After this written agreement is executed, the Division of
1696 Medicaid and the State Department of Health shall not certify any
1697 of the beds in the nursing facility for participation in the
1698 Medicaid program. If the nursing facility violates the terms of
1699 the written agreement by admitting or keeping in the nursing
1700 facility on a regular or continuing basis any patients who are
1701 participating in the Medicaid program, the State Department of
1702 Health shall revoke the license of the nursing facility, at the
1703 time that the department determines, after a hearing complying
1704 with due process, that the nursing facility has violated the
1705 condition upon which the certificate of need was issued, as
1706 provided in this paragraph and in the written agreement. If the
1707 certificate of need authorized under this paragraph is not issued
1708 within twelve (12) months after July 1, 2001, the department shall
1709 deny the application for the certificate of need and shall not
1710 issue the certificate of need at any time after the twelve-month
1711 period, unless the issuance is contested. If the certificate of
1712 need is issued and substantial construction of the nursing
1713 facility beds has not commenced within eighteen (18) months after
1714 July 1, 2001, the State Department of Health, after a hearing
1715 complying with due process, shall revoke the certificate of need
1716 if it is still outstanding, and the department shall not issue a
1717 license for the nursing facility at any time after the
1718 eighteen-month period. Provided, however, that if the issuance of
1719 the certificate of need is contested, the department shall require
1720 substantial construction of the nursing facility beds within six
1721 (6) months after final adjudication on the issuance of the
1722 certificate of need.

1723 (n) The department may issue a certificate of need for
1724 the new construction, addition or conversion of skilled nursing
1725 facility beds in Madison County, provided that the recipient of



1726 the certificate of need agrees in writing that the skilled nursing
1727 facility will not at any time participate in the Medicaid program
1728 (Section 43-13-101 et seq.) or admit or keep any patients in the
1729 skilled nursing facility who are participating in the Medicaid
1730 program. This written agreement by the recipient of the
1731 certificate of need shall be fully binding on any subsequent owner
1732 of the skilled nursing facility, if the ownership of the facility
1733 is transferred at any time after the issuance of the certificate
1734 of need. Agreement that the skilled nursing facility will not
1735 participate in the Medicaid program shall be a condition of the
1736 issuance of a certificate of need to any person under this
1737 paragraph (n), and if such skilled nursing facility at any time
1738 after the issuance of the certificate of need, regardless of the
1739 ownership of the facility, participates in the Medicaid program or
1740 admits or keeps any patients in the facility who are participating
1741 in the Medicaid program, the State Department of Health shall
1742 revoke the certificate of need, if it is still outstanding, and
1743 shall deny or revoke the license of the skilled nursing facility,
1744 at the time that the department determines, after a hearing
1745 complying with due process, that the facility has failed to comply
1746 with any of the conditions upon which the certificate of need was
1747 issued, as provided in this paragraph and in the written agreement
1748 by the recipient of the certificate of need. The total number of
1749 nursing facility beds that may be authorized by any certificate of
1750 need issued under this paragraph (n) shall not exceed sixty (60)
1751 beds. If the certificate of need authorized under this paragraph
1752 is not issued within twelve (12) months after July 1, 1998, the
1753 department shall deny the application for the certificate of need
1754 and shall not issue the certificate of need at any time after the
1755 twelve-month period, unless the issuance is contested. If the
1756 certificate of need is issued and substantial construction of the
1757 nursing facility beds has not commenced within eighteen (18)
1758 months after the effective date of July 1, 1998, the State



1759 Department of Health, after a hearing complying with due process,
1760 shall revoke the certificate of need if it is still outstanding,
1761 and the department shall not issue a license for the nursing
1762 facility at any time after the eighteen-month period. Provided,
1763 however, that if the issuance of the certificate of need is
1764 contested, the department shall require substantial construction
1765 of the nursing facility beds within six (6) months after final
1766 adjudication on the issuance of the certificate of need.

1767 (o) The department may issue a certificate of need for
1768 the new construction, addition or conversion of skilled nursing
1769 facility beds in Leake County, provided that the recipient of the
1770 certificate of need agrees in writing that the skilled nursing
1771 facility will not at any time participate in the Medicaid program
1772 (Section 43-13-101 et seq.) or admit or keep any patients in the
1773 skilled nursing facility who are participating in the Medicaid
1774 program. This written agreement by the recipient of the
1775 certificate of need shall be fully binding on any subsequent owner
1776 of the skilled nursing facility, if the ownership of the facility
1777 is transferred at any time after the issuance of the certificate
1778 of need. Agreement that the skilled nursing facility will not
1779 participate in the Medicaid program shall be a condition of the
1780 issuance of a certificate of need to any person under this
1781 paragraph (o), and if such skilled nursing facility at any time
1782 after the issuance of the certificate of need, regardless of the
1783 ownership of the facility, participates in the Medicaid program or
1784 admits or keeps any patients in the facility who are participating
1785 in the Medicaid program, the State Department of Health shall
1786 revoke the certificate of need, if it is still outstanding, and
1787 shall deny or revoke the license of the skilled nursing facility,
1788 at the time that the department determines, after a hearing
1789 complying with due process, that the facility has failed to comply
1790 with any of the conditions upon which the certificate of need was
1791 issued, as provided in this paragraph and in the written agreement



1792 by the recipient of the certificate of need. The total number of
1793 nursing facility beds that may be authorized by any certificate of
1794 need issued under this paragraph (o) shall not exceed sixty (60)
1795 beds. If the certificate of need authorized under this paragraph
1796 is not issued within twelve (12) months after July 1, 2001, the
1797 department shall deny the application for the certificate of need
1798 and shall not issue the certificate of need at any time after the
1799 twelve-month period, unless the issuance is contested. If the
1800 certificate of need is issued and substantial construction of the
1801 nursing facility beds has not commenced within eighteen (18)
1802 months after the effective date of July 1, 2001, the State
1803 Department of Health, after a hearing complying with due process,
1804 shall revoke the certificate of need if it is still outstanding,
1805 and the department shall not issue a license for the nursing
1806 facility at any time after the eighteen-month period. Provided,
1807 however, that if the issuance of the certificate of need is
1808 contested, the department shall require substantial construction
1809 of the nursing facility beds within six (6) months after final
1810 adjudication on the issuance of the certificate of need.

1811 (p) The department may issue a certificate of need for
1812 the construction of a municipally-owned nursing facility within
1813 the Town of Belmont in Tishomingo County, not to exceed sixty (60)
1814 beds, provided that the recipient of the certificate of need
1815 agrees in writing that the skilled nursing facility will not at
1816 any time participate in the Medicaid program (Section 43-13-101 et
1817 seq.) or admit or keep any patients in the skilled nursing
1818 facility who are participating in the Medicaid program. This
1819 written agreement by the recipient of the certificate of need
1820 shall be fully binding on any subsequent owner of the skilled
1821 nursing facility, if the ownership of the facility is transferred
1822 at any time after the issuance of the certificate of need.

1823 Agreement that the skilled nursing facility will not participate
1824 in the Medicaid program shall be a condition of the issuance of a



1825 certificate of need to any person under this paragraph (p), and if
1826 such skilled nursing facility at any time after the issuance of
1827 the certificate of need, regardless of the ownership of the
1828 facility, participates in the Medicaid program or admits or keeps
1829 any patients in the facility who are participating in the Medicaid
1830 program, the State Department of Health shall revoke the
1831 certificate of need, if it is still outstanding, and shall deny or
1832 revoke the license of the skilled nursing facility, at the time
1833 that the department determines, after a hearing complying with due
1834 process, that the facility has failed to comply with any of the
1835 conditions upon which the certificate of need was issued, as
1836 provided in this paragraph and in the written agreement by the
1837 recipient of the certificate of need. The provision of Section
1838 43-7-193(1) regarding substantial compliance of the projection of
1839 need as reported in the current State Health Plan is waived for
1840 the purposes of this paragraph. If the certificate of need
1841 authorized under this paragraph is not issued within twelve (12)
1842 months after July 1, 1998, the department shall deny the
1843 application for the certificate of need and shall not issue the
1844 certificate of need at any time after the twelve-month period,
1845 unless the issuance is contested. If the certificate of need is
1846 issued and substantial construction of the nursing facility beds
1847 has not commenced within eighteen (18) months after July 1, 1998,
1848 the State Department of Health, after a hearing complying with due
1849 process, shall revoke the certificate of need if it is still
1850 outstanding, and the department shall not issue a license for the
1851 nursing facility at any time after the eighteen-month period.
1852 Provided, however, that if the issuance of the certificate of need
1853 is contested, the department shall require substantial
1854 construction of the nursing facility beds within six (6) months
1855 after final adjudication on the issuance of the certificate of
1856 need.



1857 (q) (i) Beginning on July 1, 1999, the State
1858 Department of Health shall issue certificates of need during each
1859 of the next four (4) fiscal years for the construction or
1860 expansion of nursing facility beds or the conversion of other beds
1861 to nursing facility beds in each county in the state having a need
1862 for fifty (50) or more additional nursing facility beds, as shown
1863 in the fiscal year 1999 State Health Plan, in the manner provided
1864 in this paragraph (q). The total number of nursing facility beds
1865 that may be authorized by any certificate of need authorized under
1866 this paragraph (q) shall not exceed sixty (60) beds.

1867 (ii) Subject to the provisions of subparagraph
1868 (v), during each of the next four (4) fiscal years, the department
1869 shall issue six (6) certificates of need for new nursing facility
1870 beds, as follows: During fiscal years 2000, 2001 and 2002, one
1871 (1) certificate of need shall be issued for new nursing facility
1872 beds in the county in each of the four (4) Long-Term Care Planning
1873 Districts designated in the fiscal year 1999 State Health Plan
1874 that has the highest need in the district for those beds; and two
1875 (2) certificates of need shall be issued for new nursing facility
1876 beds in the two (2) counties from the state at large that have the
1877 highest need in the state for those beds, when considering the
1878 need on a statewide basis and without regard to the Long-Term Care
1879 Planning Districts in which the counties are located. During
1880 fiscal year 2003, one (1) certificate of need shall be issued for
1881 new nursing facility beds in any county having a need for fifty
1882 (50) or more additional nursing facility beds, as shown in the
1883 fiscal year 1999 State Health Plan, that has not received a
1884 certificate of need under this paragraph (q) during the three (3)
1885 previous fiscal years. During fiscal year 2000, in addition to
1886 the six (6) certificates of need authorized in this subparagraph,
1887 the department also shall issue a certificate of need for new
1888 nursing facility beds in Amite County and a certificate of need
1889 for new nursing facility beds in Carroll County.



1890 (iii) Subject to the provisions of subparagraph
1891 (v), the certificate of need issued under subparagraph (ii) for
1892 nursing facility beds in each Long-Term Care Planning District
1893 during each fiscal year shall first be available for nursing
1894 facility beds in the county in the district having the highest
1895 need for those beds, as shown in the fiscal year 1999 State Health
1896 Plan. If there are no applications for a certificate of need for
1897 nursing facility beds in the county having the highest need for
1898 those beds by the date specified by the department, then the
1899 certificate of need shall be available for nursing facility beds
1900 in other counties in the district in descending order of the need
1901 for those beds, from the county with the second highest need to
1902 the county with the lowest need, until an application is received
1903 for nursing facility beds in an eligible county in the district.

1904 (iv) Subject to the provisions of subparagraph
1905 (v), the certificate of need issued under subparagraph (ii) for
1906 nursing facility beds in the two (2) counties from the state at
1907 large during each fiscal year shall first be available for nursing
1908 facility beds in the two (2) counties that have the highest need
1909 in the state for those beds, as shown in the fiscal year 1999
1910 State Health Plan, when considering the need on a statewide basis
1911 and without regard to the Long-Term Care Planning Districts in
1912 which the counties are located. If there are no applications for
1913 a certificate of need for nursing facility beds in either of the
1914 two (2) counties having the highest need for those beds on a
1915 statewide basis by the date specified by the department, then the
1916 certificate of need shall be available for nursing facility beds
1917 in other counties from the state at large in descending order of
1918 the need for those beds on a statewide basis, from the county with
1919 the second highest need to the county with the lowest need, until
1920 an application is received for nursing facility beds in an
1921 eligible county from the state at large.



1922 (v) If a certificate of need is authorized to be
1923 issued under this paragraph (q) for nursing facility beds in a
1924 county on the basis of the need in the Long-Term Care Planning
1925 District during any fiscal year of the four-year period, a
1926 certificate of need shall not also be available under this
1927 paragraph (q) for additional nursing facility beds in that county
1928 on the basis of the need in the state at large, and that county
1929 shall be excluded in determining which counties have the highest
1930 need for nursing facility beds in the state at large for that
1931 fiscal year. After a certificate of need has been issued under
1932 this paragraph (q) for nursing facility beds in a county during
1933 any fiscal year of the four-year period, a certificate of need
1934 shall not be available again under this paragraph (q) for
1935 additional nursing facility beds in that county during the
1936 four-year period, and that county shall be excluded in determining
1937 which counties have the highest need for nursing facility beds in
1938 succeeding fiscal years.

1939 (vi) If more than one (1) application is made for
1940 a certificate of need for nursing home facility beds available
1941 under this paragraph (q), in Yalobusha, Newton or Tallahatchie
1942 County, and one (1) of the applicants is a county-owned hospital
1943 located in the county where the nursing facility beds are
1944 available, the department shall give priority to the county-owned
1945 hospital in granting the certificate of need if the following
1946 conditions are met:

1947 1. The county-owned hospital fully meets all
1948 applicable criteria and standards required to obtain a certificate
1949 of need for the nursing facility beds; and

1950 2. The county-owned hospital's qualifications
1951 for the certificate of need, as shown in its application and as
1952 determined by the department, are at least equal to the
1953 qualifications of the other applicants for the certificate of
1954 need.



1955 (r) (i) Beginning on July 1, 1999, the State
1956 Department of Health shall issue certificates of need during each
1957 of the next two (2) fiscal years for the construction or expansion
1958 of nursing facility beds or the conversion of other beds to
1959 nursing facility beds in each of the four (4) Long-Term Care
1960 Planning Districts designated in the fiscal year 1999 State Health
1961 Plan, to provide care exclusively to patients with Alzheimer's
1962 disease.

1963 (ii) Not more than twenty (20) beds may be
1964 authorized by any certificate of need issued under this paragraph
1965 (r), and not more than a total of sixty (60) beds may be
1966 authorized in any Long-Term Care Planning District by all
1967 certificates of need issued under this paragraph (r). However,
1968 the total number of beds that may be authorized by all
1969 certificates of need issued under this paragraph (r) during any
1970 fiscal year shall not exceed one hundred twenty (120) beds, and
1971 the total number of beds that may be authorized in any Long-Term
1972 Care Planning District during any fiscal year shall not exceed
1973 forty (40) beds. Of the certificates of need that are issued for
1974 each Long-Term Care Planning District during the next two (2)
1975 fiscal years, at least one (1) shall be issued for beds in the
1976 northern part of the district, at least one (1) shall be issued
1977 for beds in the central part of the district, and at least one (1)
1978 shall be issued for beds in the southern part of the district.

1979 (iii) The State Department of Health, in
1980 consultation with the Department of Mental Health and the Division
1981 of Medicaid, shall develop and prescribe the staffing levels,
1982 space requirements and other standards and requirements that must
1983 be met with regard to the nursing facility beds authorized under
1984 this paragraph (r) to provide care exclusively to patients with
1985 Alzheimer's disease.

1986 (3) The State Department of Health may grant approval for
1987 and issue certificates of need to any person proposing the new



1988 construction of, addition to, conversion of beds of or expansion
1989 of any health care facility defined in subparagraph (x)
1990 (psychiatric residential treatment facility) of Section
1991 41-7-173(h). The total number of beds which may be authorized by
1992 such certificates of need shall not exceed three hundred
1993 thirty-four (334) beds for the entire state.

1994 (a) Of the total number of beds authorized under this
1995 subsection, the department shall issue a certificate of need to a
1996 privately-owned psychiatric residential treatment facility in
1997 Simpson County for the conversion of sixteen (16) intermediate
1998 care facility for the mentally retarded (ICF-MR) beds to
1999 psychiatric residential treatment facility beds, provided that
2000 facility agrees in writing that the facility shall give priority
2001 for the use of those sixteen (16) beds to Mississippi residents
2002 who are presently being treated in out-of-state facilities.

2003 (b) Of the total number of beds authorized under this
2004 subsection, the department may issue a certificate or certificates
2005 of need for the construction or expansion of psychiatric
2006 residential treatment facility beds or the conversion of other
2007 beds to psychiatric residential treatment facility beds in Warren
2008 County, not to exceed sixty (60) psychiatric residential treatment
2009 facility beds, provided that the facility agrees in writing that
2010 no more than thirty (30) of the beds at the psychiatric
2011 residential treatment facility will be certified for participation
2012 in the Medicaid program (Section 43-13-101 et seq.) for the use of
2013 any patients other than those who are participating only in the
2014 Medicaid program of another state, and that no claim will be
2015 submitted to the Division of Medicaid for Medicaid reimbursement
2016 for more than thirty (30) patients in the psychiatric residential
2017 treatment facility in any day or for any patient in the
2018 psychiatric residential treatment facility who is in a bed that is
2019 not Medicaid-certified. This written agreement by the recipient
2020 of the certificate of need shall be a condition of the issuance of



2021 the certificate of need under this paragraph, and the agreement
2022 shall be fully binding on any subsequent owner of the psychiatric
2023 residential treatment facility if the ownership of the facility is
2024 transferred at any time after the issuance of the certificate of
2025 need. After this written agreement is executed, the Division of
2026 Medicaid and the State Department of Health shall not certify more
2027 than thirty (30) of the beds in the psychiatric residential
2028 treatment facility for participation in the Medicaid program for
2029 the use of any patients other than those who are participating
2030 only in the Medicaid program of another state. If the psychiatric
2031 residential treatment facility violates the terms of the written
2032 agreement by admitting or keeping in the facility on a regular or
2033 continuing basis more than thirty (30) patients who are
2034 participating in the Mississippi Medicaid program, the State
2035 Department of Health shall revoke the license of the facility, at
2036 the time that the department determines, after a hearing complying
2037 with due process, that the facility has violated the condition
2038 upon which the certificate of need was issued, as provided in this
2039 paragraph and in the written agreement.

2040 The State Department of Health, on or before July 1, 2002,
2041 shall transfer the certificate of need authorized under the
2042 authority of this paragraph (b), or reissue the certificate of
2043 need if it has expired, to River Region Health System.

2044 (c) Of the total number of beds authorized under this
2045 subsection, the department shall issue a certificate of need to a
2046 hospital currently operating Medicaid-certified acute psychiatric
2047 beds for adolescents in DeSoto County, for the establishment of a
2048 forty-bed psychiatric residential treatment facility in DeSoto
2049 County, provided that the hospital agrees in writing (i) that the
2050 hospital shall give priority for the use of those forty (40) beds
2051 to Mississippi residents who are presently being treated in
2052 out-of-state facilities, and (ii) that no more than fifteen (15)
2053 of the beds at the psychiatric residential treatment facility will



2054 be certified for participation in the Medicaid program (Section
2055 43-13-101 et seq.), and that no claim will be submitted for
2056 Medicaid reimbursement for more than fifteen (15) patients in the
2057 psychiatric residential treatment facility in any day or for any
2058 patient in the psychiatric residential treatment facility who is
2059 in a bed that is not Medicaid-certified. This written agreement
2060 by the recipient of the certificate of need shall be a condition
2061 of the issuance of the certificate of need under this paragraph,
2062 and the agreement shall be fully binding on any subsequent owner
2063 of the psychiatric residential treatment facility if the ownership
2064 of the facility is transferred at any time after the issuance of
2065 the certificate of need. After this written agreement is
2066 executed, the Division of Medicaid and the State Department of
2067 Health shall not certify more than fifteen (15) of the beds in the
2068 psychiatric residential treatment facility for participation in
2069 the Medicaid program. If the psychiatric residential treatment
2070 facility violates the terms of the written agreement by admitting
2071 or keeping in the facility on a regular or continuing basis more
2072 than fifteen (15) patients who are participating in the Medicaid
2073 program, the State Department of Health shall revoke the license
2074 of the facility, at the time that the department determines, after
2075 a hearing complying with due process, that the facility has
2076 violated the condition upon which the certificate of need was
2077 issued, as provided in this paragraph and in the written
2078 agreement.

2079 (d) Of the total number of beds authorized under this
2080 subsection, the department may issue a certificate or certificates
2081 of need for the construction or expansion of psychiatric
2082 residential treatment facility beds or the conversion of other
2083 beds to psychiatric treatment facility beds, not to exceed thirty
2084 (30) psychiatric residential treatment facility beds, in either
2085 Alcorn, Tishomingo, Prentiss, Lee, Itawamba, Monroe, Chickasaw,
2086 Pontotoc, Calhoun, Lafayette, Union, Benton or Tippah County.



2087 (e) Of the total number of beds authorized under this
2088 subsection (3) the department shall issue a certificate of need to
2089 a privately-owned, nonprofit psychiatric residential treatment
2090 facility in Hinds County for an eight-bed expansion of the
2091 facility, provided that the facility agrees in writing that the
2092 facility shall give priority for the use of those eight (8) beds
2093 to Mississippi residents who are presently being treated in
2094 out-of-state facilities.

2095 (f) The department shall issue a certificate of need to
2096 a one-hundred-thirty-four-bed specialty hospital located on
2097 twenty-nine and forty-four one-hundredths (29.44) commercial acres
2098 at 5900 Highway 39 North in Meridian (Lauderdale County),
2099 Mississippi, for the addition, construction or expansion of
2100 child/adolescent psychiatric residential treatment facility beds
2101 in Lauderdale County. As a condition of issuance of the
2102 certificate of need under this paragraph, the facility shall give
2103 priority in admissions to the child/adolescent psychiatric
2104 residential treatment facility beds authorized under this
2105 paragraph to patients who otherwise would require out-of-state
2106 placement. The Division of Medicaid, in conjunction with the
2107 Department of Human Services, shall furnish the facility a list of
2108 all out-of-state patients on a quarterly basis. Furthermore,
2109 notice shall also be provided to the parent, custodial parent or
2110 guardian of each out-of-state patient notifying them of the
2111 priority status granted by this paragraph. For purposes of this
2112 paragraph, the provisions of Section 41-7-193(1) requiring
2113 substantial compliance with the projection of need as reported in
2114 the current State Health Plan are waived. The total number of
2115 child/adolescent psychiatric residential treatment facility beds
2116 that may be authorized under the authority of this paragraph shall
2117 be sixty (60) beds. There shall be no prohibition or restrictions
2118 on participation in the Medicaid program (Section 43-13-101 et
2119 seq.) for the person receiving the certificate of need authorized



2120 under this paragraph or for the beds converted pursuant to the
2121 authority of that certificate of need.

2122 (4) (a) From and after July 1, 1993, the department shall
2123 not issue a certificate of need to any person for the new
2124 construction of any hospital, psychiatric hospital or chemical
2125 dependency hospital that will contain any child/adolescent
2126 psychiatric or child/adolescent chemical dependency beds, or for
2127 the conversion of any other health care facility to a hospital,
2128 psychiatric hospital or chemical dependency hospital that will
2129 contain any child/adolescent psychiatric or child/adolescent
2130 chemical dependency beds, or for the addition of any
2131 child/adolescent psychiatric or child/adolescent chemical
2132 dependency beds in any hospital, psychiatric hospital or chemical
2133 dependency hospital, or for the conversion of any beds of another
2134 category in any hospital, psychiatric hospital or chemical
2135 dependency hospital to child/adolescent psychiatric or
2136 child/adolescent chemical dependency beds, except as hereinafter
2137 authorized:

2138 (i) The department may issue certificates of need
2139 to any person for any purpose described in this subsection,
2140 provided that the hospital, psychiatric hospital or chemical
2141 dependency hospital does not participate in the Medicaid program
2142 (Section 43-13-101 et seq.) at the time of the application for the
2143 certificate of need and the owner of the hospital, psychiatric
2144 hospital or chemical dependency hospital agrees in writing that
2145 the hospital, psychiatric hospital or chemical dependency hospital
2146 will not at any time participate in the Medicaid program or admit
2147 or keep any patients who are participating in the Medicaid program
2148 in the hospital, psychiatric hospital or chemical dependency
2149 hospital. This written agreement by the recipient of the
2150 certificate of need shall be fully binding on any subsequent owner
2151 of the hospital, psychiatric hospital or chemical dependency
2152 hospital, if the ownership of the facility is transferred at any



2153 time after the issuance of the certificate of need. Agreement
2154 that the hospital, psychiatric hospital or chemical dependency
2155 hospital will not participate in the Medicaid program shall be a
2156 condition of the issuance of a certificate of need to any person
2157 under this subparagraph (a)(i), and if such hospital, psychiatric
2158 hospital or chemical dependency hospital at any time after the
2159 issuance of the certificate of need, regardless of the ownership
2160 of the facility, participates in the Medicaid program or admits or
2161 keeps any patients in the hospital, psychiatric hospital or
2162 chemical dependency hospital who are participating in the Medicaid
2163 program, the State Department of Health shall revoke the
2164 certificate of need, if it is still outstanding, and shall deny or
2165 revoke the license of the hospital, psychiatric hospital or
2166 chemical dependency hospital, at the time that the department
2167 determines, after a hearing complying with due process, that the
2168 hospital, psychiatric hospital or chemical dependency hospital has
2169 failed to comply with any of the conditions upon which the
2170 certificate of need was issued, as provided in this subparagraph
2171 and in the written agreement by the recipient of the certificate
2172 of need.

2173 (ii) The department may issue a certificate of
2174 need for the conversion of existing beds in a county hospital in
2175 Choctaw County from acute care beds to child/adolescent chemical
2176 dependency beds. For purposes of this subparagraph, the
2177 provisions of Section 41-7-193(1) requiring substantial compliance
2178 with the projection of need as reported in the current State
2179 Health Plan is waived. The total number of beds that may be
2180 authorized under authority of this subparagraph shall not exceed
2181 twenty (20) beds. There shall be no prohibition or restrictions
2182 on participation in the Medicaid program (Section 43-13-101 et
2183 seq.) for the hospital receiving the certificate of need
2184 authorized under this subparagraph (a)(ii) or for the beds
2185 converted pursuant to the authority of that certificate of need.



2186 (iii) The department may issue a certificate or
2187 certificates of need for the construction or expansion of
2188 child/adolescent psychiatric beds or the conversion of other beds
2189 to child/adolescent psychiatric beds in Warren County. For
2190 purposes of this subparagraph, the provisions of Section
2191 41-7-193(1) requiring substantial compliance with the projection
2192 of need as reported in the current State Health Plan are waived.
2193 The total number of beds that may be authorized under the
2194 authority of this subparagraph shall not exceed twenty (20) beds.
2195 There shall be no prohibition or restrictions on participation in
2196 the Medicaid program (Section 43-13-101 et seq.) for the person
2197 receiving the certificate of need authorized under this
2198 subparagraph (a)(iii) or for the beds converted pursuant to the
2199 authority of that certificate of need.

2200 If by January 1, 2002, there has been no significant
2201 commencement of construction of the beds authorized under this
2202 subparagraph (a)(iii), or no significant action taken to convert
2203 existing beds to the beds authorized under this subparagraph, then
2204 the certificate of need that was previously issued under this
2205 subparagraph shall expire. If the previously issued certificate
2206 of need expires, the department may accept applications for
2207 issuance of another certificate of need for the beds authorized
2208 under this subparagraph, and may issue a certificate of need to
2209 authorize the construction, expansion or conversion of the beds
2210 authorized under this subparagraph.

2211 (iv) The department shall issue a certificate of
2212 need to the Region 7 Mental Health/Retardation Commission for the
2213 construction or expansion of child/adolescent psychiatric beds or
2214 the conversion of other beds to child/adolescent psychiatric beds
2215 in any of the counties served by the commission. For purposes of
2216 this subparagraph, the provisions of Section 41-7-193(1) requiring
2217 substantial compliance with the projection of need as reported in
2218 the current State Health Plan is waived. The total number of beds



2219 that may be authorized under the authority of this subparagraph
2220 shall not exceed twenty (20) beds. There shall be no prohibition
2221 or restrictions on participation in the Medicaid program (Section
2222 43-13-101 et seq.) for the person receiving the certificate of
2223 need authorized under this subparagraph (a)(iv) or for the beds
2224 converted pursuant to the authority of that certificate of need.

2225 (v) The department may issue a certificate of need
2226 to any county hospital located in Leflore County for the
2227 construction or expansion of adult psychiatric beds or the
2228 conversion of other beds to adult psychiatric beds, not to exceed
2229 twenty (20) beds, provided that the recipient of the certificate
2230 of need agrees in writing that the adult psychiatric beds will not
2231 at any time be certified for participation in the Medicaid program
2232 and that the hospital will not admit or keep any patients who are
2233 participating in the Medicaid program in any of such adult
2234 psychiatric beds. This written agreement by the recipient of the
2235 certificate of need shall be fully binding on any subsequent owner
2236 of the hospital if the ownership of the hospital is transferred at
2237 any time after the issuance of the certificate of need. Agreement
2238 that the adult psychiatric beds will not be certified for
2239 participation in the Medicaid program shall be a condition of the
2240 issuance of a certificate of need to any person under this
2241 subparagraph (a)(v), and if such hospital at any time after the
2242 issuance of the certificate of need, regardless of the ownership
2243 of the hospital, has any of such adult psychiatric beds certified
2244 for participation in the Medicaid program or admits or keeps any
2245 Medicaid patients in such adult psychiatric beds, the State
2246 Department of Health shall revoke the certificate of need, if it
2247 is still outstanding, and shall deny or revoke the license of the
2248 hospital at the time that the department determines, after a
2249 hearing complying with due process, that the hospital has failed
2250 to comply with any of the conditions upon which the certificate of



2251 need was issued, as provided in this subparagraph and in the
2252 written agreement by the recipient of the certificate of need.

2253 (vi) The department may issue a certificate or
2254 certificates of need for the expansion of child psychiatric beds
2255 or the conversion of other beds to child psychiatric beds at the
2256 University of Mississippi Medical Center. For purposes of this
2257 subparagraph (a)(vi), the provision of Section 41-7-193(1)
2258 requiring substantial compliance with the projection of need as
2259 reported in the current State Health Plan is waived. The total
2260 number of beds that may be authorized under the authority of this
2261 subparagraph (a)(vi) shall not exceed fifteen (15) beds. There
2262 shall be no prohibition or restrictions on participation in the
2263 Medicaid program (Section 43-13-101 et seq.) for the hospital
2264 receiving the certificate of need authorized under this
2265 subparagraph (a)(vi) or for the beds converted pursuant to the
2266 authority of that certificate of need.

2267 (b) From and after July 1, 1990, no hospital,
2268 psychiatric hospital or chemical dependency hospital shall be
2269 authorized to add any child/adolescent psychiatric or
2270 child/adolescent chemical dependency beds or convert any beds of
2271 another category to child/adolescent psychiatric or
2272 child/adolescent chemical dependency beds without a certificate of
2273 need under the authority of subsection (1)(c) of this section.

2274 (5) The department may issue a certificate of need to a
2275 county hospital in Winston County for the conversion of fifteen
2276 (15) acute care beds to geriatric psychiatric care beds.

2277 (6) The State Department of Health shall issue a certificate
2278 of need to a Mississippi corporation qualified to manage a
2279 long-term care hospital as defined in Section 41-7-173(h)(xii) in
2280 Harrison County, not to exceed eighty (80) beds, including any
2281 necessary renovation or construction required for licensure and
2282 certification, provided that the recipient of the certificate of
2283 need agrees in writing that the long-term care hospital will not



2284 at any time participate in the Medicaid program (Section 43-13-101
2285 et seq.) or admit or keep any patients in the long-term care
2286 hospital who are participating in the Medicaid program. This
2287 written agreement by the recipient of the certificate of need
2288 shall be fully binding on any subsequent owner of the long-term
2289 care hospital, if the ownership of the facility is transferred at
2290 any time after the issuance of the certificate of need. Agreement
2291 that the long-term care hospital will not participate in the
2292 Medicaid program shall be a condition of the issuance of a
2293 certificate of need to any person under this subsection (6), and
2294 if such long-term care hospital at any time after the issuance of
2295 the certificate of need, regardless of the ownership of the
2296 facility, participates in the Medicaid program or admits or keeps
2297 any patients in the facility who are participating in the Medicaid
2298 program, the State Department of Health shall revoke the
2299 certificate of need, if it is still outstanding, and shall deny or
2300 revoke the license of the long-term care hospital, at the time
2301 that the department determines, after a hearing complying with due
2302 process, that the facility has failed to comply with any of the
2303 conditions upon which the certificate of need was issued, as
2304 provided in this subsection and in the written agreement by the
2305 recipient of the certificate of need. For purposes of this
2306 subsection, the provision of Section 41-7-193(1) requiring
2307 substantial compliance with the projection of need as reported in
2308 the current State Health Plan is hereby waived.

2309 (7) The State Department of Health may issue a certificate
2310 of need to any hospital in the state to utilize a portion of its
2311 beds for the "swing-bed" concept. Any such hospital must be in
2312 conformance with the federal regulations regarding such swing-bed
2313 concept at the time it submits its application for a certificate
2314 of need to the State Department of Health, except that such
2315 hospital may have more licensed beds or a higher average daily
2316 census (ADC) than the maximum number specified in federal



2317 regulations for participation in the swing-bed program. Any
2318 hospital meeting all federal requirements for participation in the
2319 swing-bed program which receives such certificate of need shall
2320 render services provided under the swing-bed concept to any
2321 patient eligible for Medicare (Title XVIII of the Social Security
2322 Act) who is certified by a physician to be in need of such
2323 services, and no such hospital shall permit any patient who is
2324 eligible for both Medicaid and Medicare or eligible only for
2325 Medicaid to stay in the swing beds of the hospital for more than
2326 thirty (30) days per admission unless the hospital receives prior
2327 approval for such patient from the Division of Medicaid, Office of
2328 the Governor. Any hospital having more licensed beds or a higher
2329 average daily census (ADC) than the maximum number specified in
2330 federal regulations for participation in the swing-bed program
2331 which receives such certificate of need shall develop a procedure
2332 to insure that before a patient is allowed to stay in the swing
2333 beds of the hospital, there are no vacant nursing home beds
2334 available for that patient located within a fifty-mile radius of
2335 the hospital. When any such hospital has a patient staying in the
2336 swing beds of the hospital and the hospital receives notice from a
2337 nursing home located within such radius that there is a vacant bed
2338 available for that patient, the hospital shall transfer the
2339 patient to the nursing home within a reasonable time after receipt
2340 of the notice. Any hospital which is subject to the requirements
2341 of the two (2) preceding sentences of this subsection may be
2342 suspended from participation in the swing-bed program for a
2343 reasonable period of time by the State Department of Health if the
2344 department, after a hearing complying with due process, determines
2345 that the hospital has failed to comply with any of those
2346 requirements.

2347 (8) The Department of Health shall not grant approval for or
2348 issue a certificate of need to any person proposing the new
2349 construction of, addition to or expansion of a health care



2350 facility as defined in subparagraph (viii) of Section 41-7-173(h).

2351 (9) The Department of Health shall not grant approval for or
2352 issue a certificate of need to any person proposing the
2353 establishment of, or expansion of the currently approved territory
2354 of, or the contracting to establish a home office, subunit or
2355 branch office within the space operated as a health care facility
2356 as defined in Section 41-7-173(h) (i) through (viii) by a health
2357 care facility as defined in subparagraph (ix) of Section
2358 41-7-173(h).

2359 (10) Health care facilities owned and/or operated by the
2360 state or its agencies are exempt from the restraints in this
2361 section against issuance of a certificate of need if such addition
2362 or expansion consists of repairing or renovation necessary to
2363 comply with the state licensure law. This exception shall not
2364 apply to the new construction of any building by such state
2365 facility. This exception shall not apply to any health care
2366 facilities owned and/or operated by counties, municipalities,
2367 districts, unincorporated areas, other defined persons, or any
2368 combination thereof.

2369 (11) The new construction, renovation or expansion of or
2370 addition to any health care facility defined in subparagraph (ii)
2371 (psychiatric hospital), subparagraph (iv) (skilled nursing
2372 facility), subparagraph (vi) (intermediate care facility),
2373 subparagraph (viii) (intermediate care facility for the mentally
2374 retarded) and subparagraph (x) (psychiatric residential treatment
2375 facility) of Section 41-7-173(h) which is owned by the State of
2376 Mississippi and under the direction and control of the State
2377 Department of Mental Health, and the addition of new beds or the
2378 conversion of beds from one category to another in any such
2379 defined health care facility which is owned by the State of
2380 Mississippi and under the direction and control of the State
2381 Department of Mental Health, shall not require the issuance of a
2382 certificate of need under Section 41-7-171 et seq.,



2383 notwithstanding any provision in Section 41-7-171 et seq. to the
2384 contrary.

2385 (12) The new construction, renovation or expansion of or
2386 addition to any veterans homes or domiciliaries for eligible
2387 veterans of the State of Mississippi as authorized under Section
2388 35-1-19 shall not require the issuance of a certificate of need,
2389 notwithstanding any provision in Section 41-7-171 et seq. to the
2390 contrary.

2391 (13) The new construction of a nursing facility or nursing
2392 facility beds or the conversion of other beds to nursing facility
2393 beds shall not require the issuance of a certificate of need,
2394 notwithstanding any provision in Section 41-7-171 et seq. to the
2395 contrary, if the conditions of this subsection are met.

2396 (a) Before any construction or conversion may be
2397 undertaken without a certificate of need, the owner of the nursing
2398 facility, in the case of an existing facility, or the applicant to
2399 construct a nursing facility, in the case of new construction,
2400 first must file a written notice of intent and sign a written
2401 agreement with the State Department of Health that the entire
2402 nursing facility will not at any time participate in or have any
2403 beds certified for participation in the Medicaid program (Section
2404 43-13-101 et seq.), will not admit or keep any patients in the
2405 nursing facility who are participating in the Medicaid program,
2406 and will not submit any claim for Medicaid reimbursement for any
2407 patient in the facility. This written agreement by the owner or
2408 applicant shall be a condition of exercising the authority under
2409 this subsection without a certificate of need, and the agreement
2410 shall be fully binding on any subsequent owner of the nursing
2411 facility if the ownership of the facility is transferred at any
2412 time after the agreement is signed. After the written agreement
2413 is signed, the Division of Medicaid and the State Department of
2414 Health shall not certify any beds in the nursing facility for
2415 participation in the Medicaid program. If the nursing facility



2416 violates the terms of the written agreement by participating in
2417 the Medicaid program, having any beds certified for participation
2418 in the Medicaid program, admitting or keeping any patient in the
2419 facility who is participating in the Medicaid program, or
2420 submitting any claim for Medicaid reimbursement for any patient in
2421 the facility, the State Department of Health shall revoke the
2422 license of the nursing facility at the time that the department
2423 determines, after a hearing complying with due process, that the
2424 facility has violated the terms of the written agreement.

2425 (b) For the purposes of this subsection, participation
2426 in the Medicaid program by a nursing facility includes Medicaid
2427 reimbursement of coinsurance and deductibles for recipients who
2428 are qualified Medicare beneficiaries and/or those who are dually
2429 eligible. Any nursing facility exercising the authority under
2430 this subsection may not bill or submit a claim to the Division of
2431 Medicaid for services to qualified Medicare beneficiaries and/or
2432 those who are dually eligible.

2433 (c) The new construction of a nursing facility or
2434 nursing facility beds or the conversion of other beds to nursing
2435 facility beds described in this section must be either a part of a
2436 completely new continuing care retirement community, as described
2437 in the latest edition of the Mississippi State Health Plan, or an
2438 addition to existing personal care and independent living
2439 components, and so that the completed project will be a continuing
2440 care retirement community, containing (i) independent living
2441 accommodations, (ii) personal care beds, and (iii) the nursing
2442 home facility beds. The three (3) components must be located on a
2443 single site and be operated as one (1) inseparable facility. The
2444 nursing facility component must contain a minimum of thirty (30)
2445 beds. Any nursing facility beds authorized by this section will
2446 not be counted against the bed need set forth in the State Health
2447 Plan, as identified in Section 41-7-171 et seq.



2448 This subsection (13) shall stand repealed from and after July
2449 1, 2005.

2450 (14) The State Department of Health shall issue a
2451 certificate of need to any hospital which is currently licensed
2452 for two hundred fifty (250) or more acute care beds and is located
2453 in any general hospital service area not having a comprehensive
2454 cancer center, for the establishment and equipping of such a
2455 center which provides facilities and services for outpatient
2456 radiation oncology therapy, outpatient medical oncology therapy,
2457 and appropriate support services including the provision of
2458 radiation therapy services. The provision of Section 41-7-193(1)
2459 regarding substantial compliance with the projection of need as
2460 reported in the current State Health Plan is waived for the
2461 purpose of this subsection.

2462 (15) The State Department of Health may authorize the
2463 transfer of hospital beds, not to exceed sixty (60) beds, from the
2464 North Panola Community Hospital to the South Panola Community
2465 Hospital. The authorization for the transfer of those beds shall
2466 be exempt from the certificate of need review process.

2467 (16) Nothing in this section or in any other provision of
2468 Section 41-7-171 et seq. shall prevent any nursing facility from
2469 designating an appropriate number of existing beds in the facility
2470 as beds for providing care exclusively to patients with
2471 Alzheimer's disease.

2472 (17) Beginning July 1, 2003, and annually thereafter, the
2473 State Department of Health shall revise the State Health Plan to
2474 include home- and community-based services located in the health
2475 service districts as authorized alternatives to institutional
2476 nursing facility services in determining the need for such
2477 additional nursing facility beds.

2478 **SECTION 8.** This act shall take effect and be in force from
2479 and after its passage.

