

By: Senator(s) Bryan, Kirby, Burton

To: Public Health and Welfare; Appropriations

SENATE BILL NO. 2700
(As Sent to Governor)

1 AN ACT TO DEFINE STANDARDS FOR THE LICENSURE OF PRESCRIBED
2 PEDIATRIC EXTENDED CARE (PPEC) CENTERS BY THE STATE DEPARTMENT OF
3 HEALTH; TO PROVIDE DEFINITIONS; TO PROVIDE EXEMPTIONS; TO REQUIRE
4 A LICENSE TO OPERATE A PPEC CENTER IN THIS STATE; TO SET FEES FOR
5 LICENSURE; TO AUTHORIZE THE STATE DEPARTMENT OF HEALTH TO
6 PROMULGATE RULES AND REGULATIONS TO IMPLEMENT STANDARDS FOR THE
7 LICENSURE OF PPEC CENTERS; TO AMEND SECTION 43-13-117, MISSISSIPPI
8 CODE OF 1972, TO AUTHORIZE MEDICAID REIMBURSEMENT FOR THE
9 OPERATION OF PPEC CENTERS; TO AMEND SECTION 41-7-191, MISSISSIPPI
10 CODE OF 1972, TO DIRECT THE STATE DEPARTMENT OF HEALTH TO ISSUE A
11 CERTIFICATE OF NEED TO A NONPROFIT VENTURE FOR A SKILLED NURSING
12 FACILITY TO PROVIDE SKILLED NURSING CARE FOR VENTILATOR DEPENDENT
13 OR OTHERWISE MEDICALLY DEPENDENT PEDIATRIC PATIENTS WHO REQUIRE
14 MEDICAL AND NURSING CARE OR REHABILITATION SERVICES; AND FOR
15 RELATED PURPOSES.

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

17 **SECTION 1. Legislative intent.** It is the intent of the
18 Legislature to develop, establish, and enforce licensure and basic
19 standards for prescribed pediatric extended care centers in order
20 to assure that the centers provide the necessary family-centered
21 medical, developmental, physiological, nutritional, psychosocial
22 and family training services.

23 **SECTION 2. Definitions.** As used in this act, the following
24 terms shall be defined as provided in this section:

25 (a) "Prescribed pediatric extended care center" or
26 "PPEC center" means any building or buildings, or other place,
27 whether operated for profit or not, which undertakes through its
28 ownership or management to provide basic nonresidential services
29 to three (3) or more medically dependent or technologically
30 dependent children who are not related to the owner or operator by
31 blood, marriage or adoption and who require such services.
32 Infants and children considered for admission to a PPEC center



33 must have complex medical conditions that require continual care.
34 Prerequisites for admission are a prescription from the child's
35 attending physician and consent of a parent or guardian.

36 (b) "Licensing agency" means the State Department of
37 Health.

38 (c) "Basic services" include, but are not limited to,
39 development, implementation and monitoring of a comprehensive
40 protocol of care, developed in conjunction with the parent or
41 guardian, which specifies the medical, nursing, psychosocial and
42 developmental therapies required by the medically dependent or
43 technologically dependent child served as well as the caregiver
44 training needs of the child's legal guardian.

45 (d) "Owner or operator" means a licensee.

46 (e) "Medical records" means medical records maintained
47 in accordance with accepted professional standards and practices
48 as specified in the rules implementing this act.

49 (f) "Medically dependent or technologically dependent
50 child" means a child who because of a medical condition requires
51 continuous therapeutic interventions or skilled nursing
52 supervision which must be prescribed by a licensed physician and
53 administered by, or under the direct supervision of, a licensed
54 registered nurse.

55 (g) "Supportive services or contracted services"
56 include, but are not limited to, speech therapy, occupational
57 therapy, physical therapy, social work, developmental, child life
58 and psychological services.

59 **SECTION 3. PPEC centers to be licensed; exemptions.** (1)

60 The licensing agency shall license and regulate all PPEC centers
61 in the state that are not exempt under subsection (2) of this
62 section. A license issued by the department is required for the
63 operation of a PPEC center in this state.



64 (2) A facility, institution or other place operated by the
65 federal government or any agency of the federal government is
66 exempt from the provisions of this chapter.

67 **SECTION 4. Separate licenses required; fee; exemption.** (1)

68 Separate licenses are required for PPEC centers maintained on
69 separate premises, even though they are operated under the same
70 management. Separate licenses are not required for separate
71 buildings on the same grounds.

72 (2) An applicant or licensee shall pay a fee for each
73 license application and annual license renewal under this act and
74 applicable rules. The amount of the fee shall be Twenty Dollars
75 (\$20.00) for each licensed bed in the PPEC, with a minimum fee of
76 Five Hundred Dollars (\$500.00) and a maximum fee of Five Thousand
77 Dollars (\$5,000.00).

78 (3) County-operated or municipally operated PPEC centers
79 applying for licensure under this act are exempt from the payment
80 of license fees.

81 **SECTION 5. Application for license; zoning.** In addition to
82 any other information in the application that is required by the
83 licensing agency, the application must contain the location of the
84 facility for which a license is sought and documentation, signed
85 by the appropriate local government official, which states that
86 the applicant has met local zoning requirements.

87 **SECTION 6. Background screening.** The licensing agency shall
88 require criminal record background screening and fingerprinting
89 for personnel by the Mississippi Department of Public Safety.

90 **SECTION 7. Denial, suspension, revocation of licensure;
91 administrative fines; grounds.** (1) The licensing agency may
92 deny, revoke, and suspend a license and impose an administrative
93 fine as provided in Section 8 of this act for the violation of any
94 provision of this act, or applicable rules.



95 (2) Any of the following actions by a PPEC center or its
96 employee is grounds for action by the licensing agency against a
97 PPEC center or its employee:

98 (a) An intentional or negligent act materially
99 affecting the health or safety of children in the PPEC center.

100 (b) A violation of the provisions of this act, or
101 applicable rules.

102 (c) Multiple and repeated violations of this act or of
103 minimum standards or rules adopted under this act.

104 **SECTION 8. Administrative fines; corrective action plans.**

105 (1) (a) If the licensing agency determines that a PPEC
106 center is not in compliance with this act, or applicable rules,
107 the licensing agency may request that the PPEC center submit a
108 corrective action plan that demonstrates a good-faith effort to
109 remedy each violation by a specific date, subject to the approval
110 of the licensing agency.

111 (b) The licensing agency may fine a PPEC center or
112 employee found in violation of this act, or applicable rules, in
113 an amount not to exceed Five Hundred Dollars (\$500.00) for each
114 violation. Such fine may not exceed Five Thousand Dollars
115 (\$5,000.00) in the aggregate.

116 (c) The failure to correct a violation by the date set
117 by the licensing agency, or the failure to comply with an approved
118 corrective action plan, is a separate violation for each day that
119 the failure continues, unless the licensing agency approves an
120 extension to a specific date.

121 (2) In determining if a fine is to be imposed and in fixing
122 the amount of any fine, the licensing agency shall consider the
123 following factors:

124 (a) The gravity of the violation, including the
125 probability that death or serious physical or emotional harm to a
126 child will result or has resulted, the severity of the actual or



127 potential harm, and the extent to which the provisions of the
128 applicable statutes or rules were violated.

129 (b) Actions taken by the owner or operator to correct
130 violations.

131 (c) Any previous violations.

132 (d) The financial benefit to the PPEC center of
133 committing or continuing the violation.

134 **SECTION 9. Closing of a PPEC center.** Whenever a PPEC center
135 voluntarily discontinues operation, it shall, at least thirty (30)
136 days before the discontinuance of operation, inform each child's
137 legal guardian of the fact and the proposed time of the
138 discontinuance.

139 **SECTION 10. Rules establishing standards.** (1) To carry out
140 the intention of the Legislature to provide safe and sanitary
141 facilities and healthful programs, the licensing agency shall
142 adopt and publish rules to implement the provisions of this act,
143 which shall include reasonable and fair standards. Any conflict
144 between these standards and those that may be set forth in local,
145 county or city ordinances shall be resolved in favor of those
146 having statewide effect. Those standards shall relate to:

147 (a) The assurance that PPEC services are family
148 centered and provide individualized medical, developmental and
149 family training services.

150 (b) The maintenance of PPEC centers, based upon the
151 size of the structure and number of children, relating to
152 plumbing, heating, lighting, ventilation and other building
153 conditions, including adequate space, which will ensure the
154 health, safety, comfort and protection from fire of the children
155 served.

156 (c) The appropriate provisions of the most recent
157 edition of the "Life Safety Code" shall be applied.

158 (d) The number and qualifications of all personnel who
159 have responsibility for the care of the children served.



160 (e) All sanitary conditions within the PPEC center and
161 its surroundings, including water supply, sewage disposal, food
162 handling and general hygiene, and maintenance thereof, which will
163 ensure the health and comfort of children served.

164 (f) Programs and basic services promoting and
165 maintaining the health and development of the children served and
166 meeting the training needs of the children's parents or legal
167 guardians.

168 (g) Supportive, contracted, other operational and
169 transportation services.

170 (h) Maintenance of appropriate medical records, data
171 and information relative to the children and programs. Those
172 records shall be maintained in the facility for inspection by the
173 agency.

174 (2) The licensing agency shall adopt rules to ensure that:

175 (a) No child attends a PPEC center for more than twelve
176 (12) hours within a twenty-four-hour period.

177 (b) No PPEC center provides services other than those
178 provided to medically or technologically dependent children.

179 **SECTION 11. Construction and renovation; requirements.** The
180 requirements for the construction or renovation of a PPEC center
181 shall comply with:

182 (a) All state and local requirements pertaining to
183 building construction standards, including plumbing, electrical
184 code, glass, manufactured buildings, accessibility for the
185 physically disabled;

186 (b) The minimum standards for physical facilities in
187 the Mississippi Child Care Standards; and

188 (c) The standards or rules adopted under this act.

189 **SECTION 12. Penalty for violation.** Any person who violates
190 any provisions of this act is guilty of a misdemeanor and, upon
191 conviction, shall be punished by a fine of not more than Ten



192 Thousand Dollars (\$10,000.00). Each day of continuing violation
193 is a separate offense.

194 **SECTION 13.** Section 43-13-117, Mississippi Code of 1972, is
195 amended as follows:

196 43-13-117. (A) Medicaid as authorized by this article shall
197 include payment of part or all of the costs, at the discretion of
198 the division, with approval of the Governor, of the following
199 types of care and services rendered to eligible applicants who
200 have been determined to be eligible for that care and services,
201 within the limits of state appropriations and federal matching
202 funds:

203 (1) Inpatient hospital services.

204 (a) The division shall allow thirty (30) days of
205 inpatient hospital care annually for all Medicaid recipients.
206 Medicaid recipients requiring transplants shall not have those
207 days included in the transplant hospital stay count against the
208 thirty-day limit for inpatient hospital care. Precertification of
209 inpatient days must be obtained as required by the division.

210 (b) From and after July 1, 1994, the Executive
211 Director of the Division of Medicaid shall amend the Mississippi
212 Title XIX Inpatient Hospital Reimbursement Plan to remove the
213 occupancy rate penalty from the calculation of the Medicaid
214 Capital Cost Component utilized to determine total hospital costs
215 allocated to the Medicaid program.

216 (c) Hospitals will receive an additional payment
217 for the implantable programmable baclofen drug pump used to treat
218 spasticity that is implanted on an inpatient basis. The payment
219 pursuant to written invoice will be in addition to the facility's
220 per diem reimbursement and will represent a reduction of costs on
221 the facility's annual cost report, and shall not exceed Ten
222 Thousand Dollars (\$10,000.00) per year per recipient.

223 (2) Outpatient hospital services.



224 (a) Emergency services. The division shall allow
225 six (6) medically necessary emergency room visits per beneficiary
226 per fiscal year.

227 (b) Other outpatient hospital services. The
228 division shall allow benefits for other medically necessary
229 outpatient hospital services (such as chemotherapy, radiation,
230 surgery and therapy), including outpatient services in a clinic or
231 other facility that is not located inside the hospital, but that
232 has been designated as an outpatient facility by the hospital, and
233 that was in operation or under construction on July 1, 2009,
234 provided that the costs and charges associated with the operation
235 of the hospital clinic are included in the hospital's cost report.
236 In addition, the Medicare thirty-five-mile rule will apply to
237 those hospital clinics not located inside the hospital that are
238 constructed after July 1, 2009. Where the same services are
239 reimbursed as clinic services, the division may revise the rate or
240 methodology of outpatient reimbursement to maintain consistency,
241 efficiency, economy and quality of care.

242 (3) Laboratory and x-ray services.

243 (4) Nursing facility services.

244 (a) The division shall make full payment to
245 nursing facilities for each day, not exceeding fifty-two (52) days
246 per year, that a patient is absent from the facility on home
247 leave. Payment may be made for the following home leave days in
248 addition to the fifty-two-day limitation: Christmas, the day
249 before Christmas, the day after Christmas, Thanksgiving, the day
250 before Thanksgiving and the day after Thanksgiving.

251 (b) From and after July 1, 1997, the division
252 shall implement the integrated case-mix payment and quality
253 monitoring system, which includes the fair rental system for
254 property costs and in which recapture of depreciation is
255 eliminated. The division may reduce the payment for hospital
256 leave and therapeutic home leave days to the lower of the case-mix



257 category as computed for the resident on leave using the
258 assessment being utilized for payment at that point in time, or a
259 case-mix score of 1.000 for nursing facilities, and shall compute
260 case-mix scores of residents so that only services provided at the
261 nursing facility are considered in calculating a facility's per
262 diem.

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

266 (d) When a facility of a category that does not
267 require a certificate of need for construction and that could not
268 be eligible for Medicaid reimbursement is constructed to nursing
269 facility specifications for licensure and certification, and the
270 facility is subsequently converted to a nursing facility under a
271 certificate of need that authorizes conversion only and the
272 applicant for the certificate of need was assessed an application
273 review fee based on capital expenditures incurred in constructing
274 the facility, the division shall allow reimbursement for capital
275 expenditures necessary for construction of the facility that were
276 incurred within the twenty-four (24) consecutive calendar months
277 immediately preceding the date that the certificate of need
278 authorizing the conversion was issued, to the same extent that
279 reimbursement would be allowed for construction of a new nursing
280 facility under a certificate of need that authorizes that
281 construction. The reimbursement authorized in this subparagraph
282 (d) may be made only to facilities the construction of which was
283 completed after June 30, 1989. Before the division shall be
284 authorized to make the reimbursement authorized in this
285 subparagraph (d), the division first must have received approval
286 from the Centers for Medicare and Medicaid Services (CMS) of the
287 change in the state Medicaid plan providing for the reimbursement.

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



290 by time studies and other valid statistical data that will
291 reimburse a nursing facility for the additional cost of caring for
292 a resident who has a diagnosis of Alzheimer's or other related
293 dementia and exhibits symptoms that require special care. Any
294 such case-mix add-on payment shall be supported by a determination
295 of additional cost. The division shall also develop and implement
296 as part of the fair rental reimbursement system for nursing
297 facility beds, an Alzheimer's resident bed depreciation enhanced
298 reimbursement system that will provide an incentive to encourage
299 nursing facilities to convert or construct beds for residents with
300 Alzheimer's or other related dementia.

301 (f) The division shall develop and implement an
302 assessment process for long-term care services. The division may
303 provide the assessment and related functions directly or through
304 contract with the area agencies on aging.

305 The division shall apply for necessary federal waivers to
306 assure that additional services providing alternatives to nursing
307 facility care are made available to applicants for nursing
308 facility care.

309 (5) Periodic screening and diagnostic services for
310 individuals under age twenty-one (21) years as are needed to
311 identify physical and mental defects and to provide health care
312 treatment and other measures designed to correct or ameliorate
313 defects and physical and mental illness and conditions discovered
314 by the screening services, regardless of whether these services
315 are included in the state plan. The division may include in its
316 periodic screening and diagnostic program those discretionary
317 services authorized under the federal regulations adopted to
318 implement Title XIX of the federal Social Security Act, as
319 amended. The division, in obtaining physical therapy services,
320 occupational therapy services, and services for individuals with
321 speech, hearing and language disorders, may enter into a
322 cooperative agreement with the State Department of Education for



323 the provision of those services to handicapped students by public
324 school districts using state funds that are provided from the
325 appropriation to the Department of Education to obtain federal
326 matching funds through the division. The division, in obtaining
327 medical and mental health assessments, treatment, care and
328 services for children who are in, or at risk of being put in, the
329 custody of the Mississippi Department of Human Services may enter
330 into a cooperative agreement with the Mississippi Department of
331 Human Services for the provision of those services using state
332 funds that are provided from the appropriation to the Department
333 of Human Services to obtain federal matching funds through the
334 division.

335 (6) Physician's services. The division shall allow
336 twelve (12) physician visits annually. All fees for physicians'
337 services that are covered only by Medicaid shall be reimbursed at
338 ninety percent (90%) of the rate established on January 1, 1999,
339 and as may be adjusted each July thereafter, under Medicare (Title
340 XVIII of the federal Social Security Act, as amended). The
341 division may develop and implement a different reimbursement model
342 or schedule for physician's services provided by physicians based
343 at an academic health care center and by physicians at rural
344 health centers that are associated with an academic health care
345 center. From and after January 1, 2010, all fees for physicians'
346 services that are covered only by Medicaid shall be increased to
347 ninety percent (90%) of the rate established on January 1, 2010,
348 and as may be adjusted each July thereafter, under Medicare.

349 (7) (a) Home health services for eligible persons, not
350 to exceed in cost the prevailing cost of nursing facility
351 services, not to exceed twenty-five (25) visits per year. All
352 home health visits must be precertified as required by the
353 division.

354 (b) [Repealed]



355 (8) Emergency medical transportation services. On
356 January 1, 1994, emergency medical transportation services shall
357 be reimbursed at seventy percent (70%) of the rate established
358 under Medicare (Title XVIII of the federal Social Security Act, as
359 amended). "Emergency medical transportation services" shall mean,
360 but shall not be limited to, the following services by a properly
361 permitted ambulance operated by a properly licensed provider in
362 accordance with the Emergency Medical Services Act of 1974
363 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
364 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
365 (vi) disposable supplies, (vii) similar services.

366 (9) (a) Legend and other drugs as may be determined by
367 the division.

368 The division shall establish a mandatory preferred drug list.
369 Drugs not on the mandatory preferred drug list shall be made
370 available by utilizing prior authorization procedures established
371 by the division.

372 The division may seek to establish relationships with other
373 states in order to lower acquisition costs of prescription drugs
374 to include single source and innovator multiple source drugs or
375 generic drugs. In addition, if allowed by federal law or
376 regulation, the division may seek to establish relationships with
377 and negotiate with other countries to facilitate the acquisition
378 of prescription drugs to include single source and innovator
379 multiple source drugs or generic drugs, if that will lower the
380 acquisition costs of those prescription drugs.

381 The division shall allow for a combination of prescriptions
382 for single source and innovator multiple source drugs and generic
383 drugs to meet the needs of the beneficiaries, not to exceed five
384 (5) prescriptions per month for each noninstitutionalized Medicaid
385 beneficiary, with not more than two (2) of those prescriptions
386 being for single source or innovator multiple source drugs.



387 The executive director may approve specific maintenance drugs
388 for beneficiaries with certain medical conditions, which may be
389 prescribed and dispensed in three-month supply increments.

390 Drugs prescribed for a resident of a psychiatric residential
391 treatment facility must be provided in true unit doses when
392 available. The division may require that drugs not covered by
393 Medicare Part D for a resident of a long-term care facility be
394 provided in true unit doses when available. Those drugs that were
395 originally billed to the division but are not used by a resident
396 in any of those facilities shall be returned to the billing
397 pharmacy for credit to the division, in accordance with the
398 guidelines of the State Board of Pharmacy and any requirements of
399 federal law and regulation. Drugs shall be dispensed to a
400 recipient and only one (1) dispensing fee per month may be
401 charged. The division shall develop a methodology for reimbursing
402 for restocked drugs, which shall include a restock fee as
403 determined by the division not exceeding Seven Dollars and
404 Eighty-two Cents (\$7.82).

405 The voluntary preferred drug list shall be expanded to
406 function in the interim in order to have a manageable prior
407 authorization system, thereby minimizing disruption of service to
408 beneficiaries.

409 Except for those specific maintenance drugs approved by the
410 executive director, the division shall not reimburse for any
411 portion of a prescription that exceeds a thirty-one-day supply of
412 the drug based on the daily dosage.

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

417 All claims for drugs for dually eligible Medicare/Medicaid
418 beneficiaries that are paid for by Medicare must be submitted to



419 Medicare for payment before they may be processed by the
420 division's online payment system.

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

426 The division shall develop and implement a method or methods
427 by which the division will provide on a regular basis to Medicaid
428 providers who are authorized to prescribe drugs, information about
429 the costs to the Medicaid program of single source drugs and
430 innovator multiple source drugs, and information about other drugs
431 that may be prescribed as alternatives to those single source
432 drugs and innovator multiple source drugs and the costs to the
433 Medicaid program of those alternative drugs.

434 Notwithstanding any law or regulation, information obtained
435 or maintained by the division regarding the prescription drug
436 program, including trade secrets and manufacturer or labeler
437 pricing, is confidential and not subject to disclosure except to
438 other state agencies.

439 (b) Payment by the division for covered
440 multisource drugs shall be limited to the lower of the upper
441 limits established and published by the Centers for Medicare and
442 Medicaid Services (CMS) plus a dispensing fee, or the estimated
443 acquisition cost (EAC) as determined by the division, plus a
444 dispensing fee, or the providers' usual and customary charge to
445 the general public.

446 Payment for other covered drugs, other than multisource drugs
447 with CMS upper limits, shall not exceed the lower of the estimated
448 acquisition cost as determined by the division, plus a dispensing
449 fee or the providers' usual and customary charge to the general
450 public.



451 Payment for nonlegend or over-the-counter drugs covered by
452 the division shall be reimbursed at the lower of the division's
453 estimated shelf price or the providers' usual and customary charge
454 to the general public.

455 The dispensing fee for each new or refill prescription,
456 including nonlegend or over-the-counter drugs covered by the
457 division, shall be not less than Three Dollars and Ninety-one
458 Cents (\$3.91), as determined by the division.

459 The division shall not reimburse for single source or
460 innovator multiple source drugs if there are equally effective
461 generic equivalents available and if the generic equivalents are
462 the least expensive.

463 It is the intent of the Legislature that the pharmacists
464 providers be reimbursed for the reasonable costs of filling and
465 dispensing prescriptions for Medicaid beneficiaries.

466 (10) (a) Dental care that is an adjunct to treatment
467 of an acute medical or surgical condition; services of oral
468 surgeons and dentists in connection with surgery related to the
469 jaw or any structure contiguous to the jaw or the reduction of any
470 fracture of the jaw or any facial bone; and emergency dental
471 extractions and treatment related thereto. On July 1, 2007, fees
472 for dental care and surgery under authority of this paragraph (10)
473 shall be reimbursed as provided in subparagraph (b). It is the
474 intent of the Legislature that this rate revision for dental
475 services will be an incentive designed to increase the number of
476 dentists who actively provide Medicaid services. This dental
477 services rate revision shall be known as the "James Russell Dumas
478 Medicaid Dental Incentive Program."

479 The division shall annually determine the effect of this
480 incentive by evaluating the number of dentists who are Medicaid
481 providers, the number who and the degree to which they are
482 actively billing Medicaid, the geographic trends of where dentists
483 are offering what types of Medicaid services and other statistics



484 pertinent to the goals of this legislative intent. This data
485 shall be presented to the Chair of the Senate Public Health and
486 Welfare Committee and the Chair of the House Medicaid Committee.

487 (b) The Division of Medicaid shall establish a fee
488 schedule, to be effective from and after July 1, 2007, for dental
489 services. The schedule shall provide for a fee for each dental
490 service that is equal to a percentile of normal and customary
491 private provider fees, as defined by the Ingenix Customized Fee
492 Analyzer Report, which percentile shall be determined by the
493 division. The schedule shall be reviewed annually by the division
494 and dental fees shall be adjusted to reflect the percentile
495 determined by the division.

496 (c) For fiscal year 2008, the amount of state
497 funds appropriated for reimbursement for dental care and surgery
498 shall be increased by ten percent (10%) of the amount of state
499 fund expenditures for that purpose for fiscal year 2007. For each
500 of fiscal years 2009 and 2010, the amount of state funds
501 appropriated for reimbursement for dental care and surgery shall
502 be increased by ten percent (10%) of the amount of state fund
503 expenditures for that purpose for the preceding fiscal year.

504 (d) The division shall establish an annual benefit
505 limit of Two Thousand Five Hundred Dollars (\$2,500.00) in dental
506 expenditures per Medicaid-eligible recipient; however, a recipient
507 may exceed the annual limit on dental expenditures provided in
508 this paragraph with prior approval of the division.

509 (e) The division shall include dental services as
510 a necessary component of overall health services provided to
511 children who are eligible for services.

512 (f) This paragraph (10) shall stand repealed on
513 July 1, 2012.

514 (11) Eyeglasses for all Medicaid beneficiaries who have
515 (a) had surgery on the eyeball or ocular muscle that results in a
516 vision change for which eyeglasses or a change in eyeglasses is



517 medically indicated within six (6) months of the surgery and is in
518 accordance with policies established by the division, or (b) one
519 (1) pair every five (5) years and in accordance with policies
520 established by the division. In either instance, the eyeglasses
521 must be prescribed by a physician skilled in diseases of the eye
522 or an optometrist, whichever the beneficiary may select.

523 (12) Intermediate care facility services.

524 (a) The division shall make full payment to all
525 intermediate care facilities for the mentally retarded for each
526 day, not exceeding eighty-four (84) days per year, that a patient
527 is absent from the facility on home leave. Payment may be made
528 for the following home leave days in addition to the
529 eighty-four-day limitation: Christmas, the day before Christmas,
530 the day after Christmas, Thanksgiving, the day before Thanksgiving
531 and the day after Thanksgiving.

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

535 (13) Family planning services, including drugs,
536 supplies and devices, when those services are under the
537 supervision of a physician or nurse practitioner.

538 (14) Clinic services. Such diagnostic, preventive,
539 therapeutic, rehabilitative or palliative services furnished to an
540 outpatient by or under the supervision of a physician or dentist
541 in a facility that is not a part of a hospital but that is
542 organized and operated to provide medical care to outpatients.
543 Clinic services shall include any services reimbursed as
544 outpatient hospital services that may be rendered in such a
545 facility, including those that become so after July 1, 1991. On
546 July 1, 1999, all fees for physicians' services reimbursed under
547 authority of this paragraph (14) shall be reimbursed at ninety
548 percent (90%) of the rate established on January 1, 1999, and as
549 may be adjusted each July thereafter, under Medicare (Title XVIII



550 of the federal Social Security Act, as amended). The division may
551 develop and implement a different reimbursement model or schedule
552 for physician's services provided by physicians based at an
553 academic health care center and by physicians at rural health
554 centers that are associated with an academic health care center.

555 (15) Home- and community-based services for the elderly
556 and disabled, as provided under Title XIX of the federal Social
557 Security Act, as amended, under waivers, subject to the
558 availability of funds specifically appropriated for that purpose
559 by the Legislature.

560 (16) Mental health services. Approved therapeutic and
561 case management services (a) provided by an approved regional
562 mental health/intellectual disability center established under
563 Sections 41-19-31 through 41-19-39, or by another community mental
564 health service provider meeting the requirements of the Department
565 of Mental Health to be an approved mental health/intellectual
566 disability center if determined necessary by the Department of
567 Mental Health, using state funds that are provided from the
568 appropriation to the State Department of Mental Health and/or
569 funds transferred to the department by a political subdivision or
570 instrumentality of the state and used to match federal funds under
571 a cooperative agreement between the division and the department,
572 or (b) provided by a facility that is certified by the State
573 Department of Mental Health to provide therapeutic and case
574 management services, to be reimbursed on a fee for service basis,
575 or (c) provided in the community by a facility or program operated
576 by the Department of Mental Health. Any such services provided by
577 a facility described in subparagraph (b) must have the prior
578 approval of the division to be reimbursable under this section.
579 After June 30, 1997, mental health services provided by regional
580 mental health/intellectual disability centers established under
581 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
582 Section 41-9-3(a) and/or their subsidiaries and divisions, or by



583 psychiatric residential treatment facilities as defined in Section
584 43-11-1, or by another community mental health service provider
585 meeting the requirements of the Department of Mental Health to be
586 an approved mental health/intellectual disability center if
587 determined necessary by the Department of Mental Health, shall not
588 be included in or provided under any capitated managed care pilot
589 program provided for under paragraph (24) of this section.

590 (17) Durable medical equipment services and medical
591 supplies. Precertification of durable medical equipment and
592 medical supplies must be obtained as required by the division.
593 The Division of Medicaid may require durable medical equipment
594 providers to obtain a surety bond in the amount and to the
595 specifications as established by the Balanced Budget Act of 1997.

596 (18) (a) Notwithstanding any other provision of this
597 section to the contrary, as provided in the Medicaid state plan
598 amendment or amendments as defined in Section 43-13-145(10), the
599 division shall make additional reimbursement to hospitals that
600 serve a disproportionate share of low-income patients and that
601 meet the federal requirements for those payments as provided in
602 Section 1923 of the federal Social Security Act and any applicable
603 regulations. It is the intent of the Legislature that the
604 division shall draw down all available federal funds allotted to
605 the state for disproportionate share hospitals. However, from and
606 after January 1, 1999, public hospitals participating in the
607 Medicaid disproportionate share program may be required to
608 participate in an intergovernmental transfer program as provided
609 in Section 1903 of the federal Social Security Act and any
610 applicable regulations.

611 (b) The division shall establish a Medicare Upper
612 Payment Limits Program, as defined in Section 1902(a)(30) of the
613 federal Social Security Act and any applicable federal
614 regulations, for hospitals, and may establish a Medicare Upper
615 Payment Limits Program for nursing facilities. The division shall



616 assess each hospital and, if the program is established for
617 nursing facilities, shall assess each nursing facility, for the
618 sole purpose of financing the state portion of the Medicare Upper
619 Payment Limits Program. The hospital assessment shall be as
620 provided in Section 43-13-145(4)(a) and the nursing facility
621 assessment, if established, shall be based on Medicaid utilization
622 or other appropriate method consistent with federal regulations.
623 The assessment will remain in effect as long as the state
624 participates in the Medicare Upper Payment Limits Program. As
625 provided in the Medicaid state plan amendment or amendments as
626 defined in Section 43-13-145(10), the division shall make
627 additional reimbursement to hospitals and, if the program is
628 established for nursing facilities, shall make additional
629 reimbursement to nursing facilities, for the Medicare Upper
630 Payment Limits, as defined in Section 1902(a)(30) of the federal
631 Social Security Act and any applicable federal regulations.

632 (19) (a) Perinatal risk management services. The
633 division shall promulgate regulations to be effective from and
634 after October 1, 1988, to establish a comprehensive perinatal
635 system for risk assessment of all pregnant and infant Medicaid
636 recipients and for management, education and follow-up for those
637 who are determined to be at risk. Services to be performed
638 include case management, nutrition assessment/counseling,
639 psychosocial assessment/counseling and health education.

640 (b) Early intervention system services. The
641 division shall cooperate with the State Department of Health,
642 acting as lead agency, in the development and implementation of a
643 statewide system of delivery of early intervention services, under
644 Part C of the Individuals with Disabilities Education Act (IDEA).
645 The State Department of Health shall certify annually in writing
646 to the executive director of the division the dollar amount of
647 state early intervention funds available that will be utilized as
648 a certified match for Medicaid matching funds. Those funds then



649 shall be used to provide expanded targeted case management
650 services for Medicaid eligible children with special needs who are
651 eligible for the state's early intervention system.

652 Qualifications for persons providing service coordination shall be
653 determined by the State Department of Health and the Division of
654 Medicaid.

655 (20) Home- and community-based services for physically
656 disabled approved services as allowed by a waiver from the United
657 States Department of Health and Human Services for home- and
658 community-based services for physically disabled people using
659 state funds that are provided from the appropriation to the State
660 Department of Rehabilitation Services and used to match federal
661 funds under a cooperative agreement between the division and the
662 department, provided that funds for these services are
663 specifically appropriated to the Department of Rehabilitation
664 Services.

665 (21) Nurse practitioner services. Services furnished
666 by a registered nurse who is licensed and certified by the
667 Mississippi Board of Nursing as a nurse practitioner, including,
668 but not limited to, nurse anesthetists, nurse midwives, family
669 nurse practitioners, family planning nurse practitioners,
670 pediatric nurse practitioners, obstetrics-gynecology nurse
671 practitioners and neonatal nurse practitioners, under regulations
672 adopted by the division. Reimbursement for those services shall
673 not exceed ninety percent (90%) of the reimbursement rate for
674 comparable services rendered by a physician.

675 (22) Ambulatory services delivered in federally
676 qualified health centers, rural health centers and clinics of the
677 local health departments of the State Department of Health for
678 individuals eligible for Medicaid under this article based on
679 reasonable costs as determined by the division.

680 (23) Inpatient psychiatric services. Inpatient
681 psychiatric services to be determined by the division for



682 recipients under age twenty-one (21) that are provided under the
683 direction of a physician in an inpatient program in a licensed
684 acute care psychiatric facility or in a licensed psychiatric
685 residential treatment facility, before the recipient reaches age
686 twenty-one (21) or, if the recipient was receiving the services
687 immediately before he or she reached age twenty-one (21), before
688 the earlier of the date he or she no longer requires the services
689 or the date he or she reaches age twenty-two (22), as provided by
690 federal regulations. Precertification of inpatient days and
691 residential treatment days must be obtained as required by the
692 division. From and after July 1, 2009, all state-owned and
693 state-operated facilities that provide inpatient psychiatric
694 services to persons under age twenty-one (21) who are eligible for
695 Medicaid reimbursement shall be reimbursed for those services on a
696 full reasonable cost basis.

697 (24) [Deleted]

698 (25) [Deleted]

699 (26) Hospice care. As used in this paragraph, the term
700 "hospice care" means a coordinated program of active professional
701 medical attention within the home and outpatient and inpatient
702 care that treats the terminally ill patient and family as a unit,
703 employing a medically directed interdisciplinary team. The
704 program provides relief of severe pain or other physical symptoms
705 and supportive care to meet the special needs arising out of
706 physical, psychological, spiritual, social and economic stresses
707 that are experienced during the final stages of illness and during
708 dying and bereavement and meets the Medicare requirements for
709 participation as a hospice as provided in federal regulations.

710 (27) Group health plan premiums and cost sharing if it
711 is cost-effective as defined by the United States Secretary of
712 Health and Human Services.

713 (28) Other health insurance premiums that are
714 cost-effective as defined by the United States Secretary of Health



715 and Human Services. Medicare eligible must have Medicare Part B
716 before other insurance premiums can be paid.

717 (29) The Division of Medicaid may apply for a waiver
718 from the United States Department of Health and Human Services for
719 home- and community-based services for developmentally disabled
720 people using state funds that are provided from the appropriation
721 to the State Department of Mental Health and/or funds transferred
722 to the department by a political subdivision or instrumentality of
723 the state and used to match federal funds under a cooperative
724 agreement between the division and the department, provided that
725 funds for these services are specifically appropriated to the
726 Department of Mental Health and/or transferred to the department
727 by a political subdivision or instrumentality of the state.

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

730 (31) Targeted case management services for children
731 with special needs, under waivers from the United States
732 Department of Health and Human Services, using state funds that
733 are provided from the appropriation to the Mississippi Department
734 of Human Services and used to match federal funds under a
735 cooperative agreement between the division and the department.

736 (32) Care and services provided in Christian Science
737 Sanatoria listed and certified by the Commission for Accreditation
738 of Christian Science Nursing Organizations/Facilities, Inc.,
739 rendered in connection with treatment by prayer or spiritual means
740 to the extent that those services are subject to reimbursement
741 under Section 1903 of the federal Social Security Act.

742 (33) Podiatrist services.

743 (34) Assisted living services as provided through home-
744 and community-based services under Title XIX of the federal Social
745 Security Act, as amended, subject to the availability of funds
746 specifically appropriated for that purpose by the Legislature.



747 (35) Services and activities authorized in Sections
748 43-27-101 and 43-27-103, using state funds that are provided from
749 the appropriation to the Mississippi Department of Human Services
750 and used to match federal funds under a cooperative agreement
751 between the division and the department.

752 (36) Nonemergency transportation services for
753 Medicaid-eligible persons, to be provided by the Division of
754 Medicaid. The division may contract with additional entities to
755 administer nonemergency transportation services as it deems
756 necessary. All providers shall have a valid driver's license,
757 vehicle inspection sticker, valid vehicle license tags and a
758 standard liability insurance policy covering the vehicle. The
759 division may pay providers a flat fee based on mileage tiers, or
760 in the alternative, may reimburse on actual miles traveled. The
761 division may apply to the Center for Medicare and Medicaid
762 Services (CMS) for a waiver to draw federal matching funds for
763 nonemergency transportation services as a covered service instead
764 of an administrative cost. The PEER Committee shall conduct a
765 performance evaluation of the nonemergency transportation program
766 to evaluate the administration of the program and the providers of
767 transportation services to determine the most cost-effective ways
768 of providing nonemergency transportation services to the patients
769 served under the program. The performance evaluation shall be
770 completed and provided to the members of the Senate Public Health
771 and Welfare Committee and the House Medicaid Committee not later
772 than January 15, 2008.

773 (37) [Deleted]

774 (38) Chiropractic services. A chiropractor's manual
775 manipulation of the spine to correct a subluxation, if x-ray
776 demonstrates that a subluxation exists and if the subluxation has
777 resulted in a neuromusculoskeletal condition for which
778 manipulation is appropriate treatment, and related spinal x-rays
779 performed to document these conditions. Reimbursement for



780 chiropractic services shall not exceed Seven Hundred Dollars
781 (\$700.00) per year per beneficiary.

782 (39) Dually eligible Medicare/Medicaid beneficiaries.
783 The division shall pay the Medicare deductible and coinsurance
784 amounts for services available under Medicare, as determined by
785 the division. From and after July 1, 2009, the division shall
786 reimburse crossover claims for inpatient hospital services and
787 crossover claims covered under Medicare Part B in the same manner
788 that was in effect on January 1, 2008, unless specifically
789 authorized by the Legislature to change this method.

790 (40) [Deleted]

791 (41) Services provided by the State Department of
792 Rehabilitation Services for the care and rehabilitation of persons
793 with spinal cord injuries or traumatic brain injuries, as allowed
794 under waivers from the United States Department of Health and
795 Human Services, using up to seventy-five percent (75%) of the
796 funds that are appropriated to the Department of Rehabilitation
797 Services from the Spinal Cord and Head Injury Trust Fund
798 established under Section 37-33-261 and used to match federal
799 funds under a cooperative agreement between the division and the
800 department.

801 (42) Notwithstanding any other provision in this
802 article to the contrary, the division may develop a population
803 health management program for women and children health services
804 through the age of one (1) year. This program is primarily for
805 obstetrical care associated with low birth weight and preterm
806 babies. The division may apply to the federal Centers for
807 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
808 any other waivers that may enhance the program. In order to
809 effect cost savings, the division may develop a revised payment
810 methodology that may include at-risk capitated payments, and may
811 require member participation in accordance with the terms and
812 conditions of an approved federal waiver.



813 (43) The division shall provide reimbursement,
814 according to a payment schedule developed by the division, for
815 smoking cessation medications for pregnant women during their
816 pregnancy and other Medicaid-eligible women who are of
817 child-bearing age.

818 (44) Nursing facility services for the severely
819 disabled.

820 (a) Severe disabilities include, but are not
821 limited to, spinal cord injuries, closed head injuries and
822 ventilator dependent patients.

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

827 (45) Physician assistant services. Services furnished
828 by a physician assistant who is licensed by the State Board of
829 Medical Licensure and is practicing with physician supervision
830 under regulations adopted by the board, under regulations adopted
831 by the division. Reimbursement for those services shall not
832 exceed ninety percent (90%) of the reimbursement rate for
833 comparable services rendered by a physician.

834 (46) The division shall make application to the federal
835 Centers for Medicare and Medicaid Services (CMS) for a waiver to
836 develop and provide services for children with serious emotional
837 disturbances as defined in Section 43-14-1(1), which may include
838 home- and community-based services, case management services or
839 managed care services through mental health providers certified by
840 the Department of Mental Health. The division may implement and
841 provide services under this waived program only if funds for
842 these services are specifically appropriated for this purpose by
843 the Legislature, or if funds are voluntarily provided by affected
844 agencies.



845 (47) (a) Notwithstanding any other provision in this
846 article to the contrary, the division may develop and implement
847 disease management programs for individuals with high-cost chronic
848 diseases and conditions, including the use of grants, waivers,
849 demonstrations or other projects as necessary.

850 (b) Participation in any disease management
851 program implemented under this paragraph (47) is optional with the
852 individual. An individual must affirmatively elect to participate
853 in the disease management program in order to participate, and may
854 elect to discontinue participation in the program at any time.

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

856 (a) Pediatric long-term acute care hospital
857 services means services provided to eligible persons under
858 twenty-one (21) years of age by a freestanding Medicare-certified
859 hospital that has an average length of inpatient stay greater than
860 twenty-five (25) days and that is primarily engaged in providing
861 chronic or long-term medical care to persons under twenty-one (21)
862 years of age.

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

865 (49) The division shall establish copayments and/or
866 coinsurance for all Medicaid services for which copayments and/or
867 coinsurance are allowable under federal law or regulation, and
868 shall set the amount of the copayment and/or coinsurance for each
869 of those services at the maximum amount allowable under federal
870 law or regulation.

871 (50) Services provided by the State Department of
872 Rehabilitation Services for the care and rehabilitation of persons
873 who are deaf and blind, as allowed under waivers from the United
874 States Department of Health and Human Services to provide home-
875 and community-based services using state funds that are provided
876 from the appropriation to the State Department of Rehabilitation
877 Services or if funds are voluntarily provided by another agency.



878 (51) Upon determination of Medicaid eligibility and in
879 association with annual redetermination of Medicaid eligibility,
880 beneficiaries shall be encouraged to undertake a physical
881 examination that will establish a base-line level of health and
882 identification of a usual and customary source of care (a medical
883 home) to aid utilization of disease management tools. This
884 physical examination and utilization of these disease management
885 tools shall be consistent with current United States Preventive
886 Services Task Force or other recognized authority recommendations.

887 For persons who are determined ineligible for Medicaid, the
888 division will provide information and direction for accessing
889 medical care and services in the area of their residence.

890 (52) Notwithstanding any provisions of this article,
891 the division may pay enhanced reimbursement fees related to trauma
892 care, as determined by the division in conjunction with the State
893 Department of Health, using funds appropriated to the State
894 Department of Health for trauma care and services and used to
895 match federal funds under a cooperative agreement between the
896 division and the State Department of Health. The division, in
897 conjunction with the State Department of Health, may use grants,
898 waivers, demonstrations, or other projects as necessary in the
899 development and implementation of this reimbursement program.

900 (53) Targeted case management services for high-cost
901 beneficiaries shall be developed by the division for all services
902 under this section.

903 (54) Adult foster care services pilot program. Social
904 and protective services on a pilot program basis in an approved
905 foster care facility for vulnerable adults who would otherwise
906 need care in a long-term care facility, to be implemented in an
907 area of the state with the greatest need for such program, under
908 the Medicaid Waivers for the Elderly and Disabled program or an
909 assisted living waiver. The division may use grants, waivers,
910 demonstrations or other projects as necessary in the development



911 and implementation of this adult foster care services pilot
912 program.

913 (55) Therapy services. The plan of care for therapy
914 services may be developed to cover a period of treatment for up to
915 six (6) months, but in no event shall the plan of care exceed a
916 six-month period of treatment. The projected period of treatment
917 must be indicated on the initial plan of care and must be updated
918 with each subsequent revised plan of care. Based on medical
919 necessity, the division shall approve certification periods for
920 less than or up to six (6) months, but in no event shall the
921 certification period exceed the period of treatment indicated on
922 the plan of care. The appeal process for any reduction in therapy
923 services shall be consistent with the appeal process in federal
924 regulations.

925 (56) Prescribed pediatric extended care centers
926 services for medically dependent or technologically dependent
927 children with complex medical conditions that require continual
928 care as prescribed by the child's attending physician, as
929 determined by the division.

930 (B) Notwithstanding any other provision of this article to
931 the contrary, the division shall reduce the rate of reimbursement
932 to providers for any service provided under this section by five
933 percent (5%) of the allowed amount for that service. However, the
934 reduction in the reimbursement rates required by this subsection
935 (B) shall not apply to inpatient hospital services, nursing
936 facility services, intermediate care facility services,
937 psychiatric residential treatment facility services, pharmacy
938 services provided under subsection (A)(9) of this section, or any
939 service provided by the University of Mississippi Medical Center
940 or a state agency, a state facility or a public agency that either
941 provides its own state match through intergovernmental transfer or
942 certification of funds to the division, or a service for which the
943 federal government sets the reimbursement methodology and rate.



944 From and after January 1, 2010, the reduction in the reimbursement
945 rates required by this subsection (B) shall not apply to
946 physicians' services. In addition, the reduction in the
947 reimbursement rates required by this subsection (B) shall not
948 apply to case management services and home-delivered meals
949 provided under the home- and community-based services program for
950 the elderly and disabled by a planning and development district
951 (PDD). Planning and development districts participating in the
952 home- and community-based services program for the elderly and
953 disabled as case management providers shall be reimbursed for case
954 management services at the maximum rate approved by the Centers
955 for Medicare and Medicaid Services (CMS).

956 (C) The division may pay to those providers who participate
957 in and accept patient referrals from the division's emergency room
958 redirection program a percentage, as determined by the division,
959 of savings achieved according to the performance measures and
960 reduction of costs required of that program. Federally qualified
961 health centers may participate in the emergency room redirection
962 program, and the division may pay those centers a percentage of
963 any savings to the Medicaid program achieved by the centers'
964 accepting patient referrals through the program, as provided in
965 this subsection (C).

966 (D) Notwithstanding any provision of this article, except as
967 authorized in the following subsection and in Section 43-13-139,
968 neither (a) the limitations on quantity or frequency of use of or
969 the fees or charges for any of the care or services available to
970 recipients under this section, nor (b) the payments, payment
971 methodology as provided below in this subsection (D), or rates of
972 reimbursement to providers rendering care or services authorized
973 under this section to recipients, may be increased, decreased or
974 otherwise changed from the levels in effect on July 1, 1999,
975 unless they are authorized by an amendment to this section by the
976 Legislature. However, the restriction in this subsection shall



977 not prevent the division from changing the payments, payment
978 methodology as provided below in this subsection (D), or rates of
979 reimbursement to providers without an amendment to this section
980 whenever those changes are required by federal law or regulation,
981 or whenever those changes are necessary to correct administrative
982 errors or omissions in calculating those payments or rates of
983 reimbursement. The prohibition on any changes in payment
984 methodology provided in this subsection (D) shall apply only to
985 payment methodologies used for determining the rates of
986 reimbursement for inpatient hospital services, outpatient hospital
987 services and/or nursing facility services, except as required by
988 federal law, and the federally mandated rebasing of rates as
989 required by the Centers for Medicare and Medicaid Services (CMS)
990 shall not be considered payment methodology for purposes of this
991 subsection (D).

992 (E) Notwithstanding any provision of this article, no new
993 groups or categories of recipients and new types of care and
994 services may be added without enabling legislation from the
995 Mississippi Legislature, except that the division may authorize
996 those changes without enabling legislation when the addition of
997 recipients or services is ordered by a court of proper authority.

998 (F) The executive director shall keep the Governor advised
999 on a timely basis of the funds available for expenditure and the
1000 projected expenditures. If current or projected expenditures of
1001 the division are reasonably anticipated to exceed the amount of
1002 funds appropriated to the division for any fiscal year, the
1003 Governor, after consultation with the executive director, shall
1004 discontinue any or all of the payment of the types of care and
1005 services as provided in this section that are deemed to be
1006 optional services under Title XIX of the federal Social Security
1007 Act, as amended, and when necessary, shall institute any other
1008 cost containment measures on any program or programs authorized
1009 under the article to the extent allowed under the federal law



1010 governing that program or programs. However, the Governor shall
1011 not be authorized to discontinue or eliminate any service under
1012 this section that is mandatory under federal law, or to
1013 discontinue or eliminate, or adjust income limits or resource
1014 limits for, any eligibility category or group under Section
1015 43-13-115. Applicable in fiscal year 2010 only, no expenditure
1016 reductions or cost containments or increases in assessments
1017 recommended by the Executive Director of the Division of Medicaid
1018 shall be implemented before February 1, unless the division
1019 projects a shortfall so great that the entire Health Care
1020 Expendable Fund balance would be reduced to zero. Beginning in
1021 fiscal year 2010 and in fiscal years thereafter, when Medicaid
1022 expenditures are projected to exceed funds available for any
1023 quarter in the fiscal year, the division shall submit the expected
1024 shortfall information to the PEER Committee, which shall review
1025 the computations of the division and report its findings to the
1026 Legislative Budget Office within thirty (30) days of such
1027 notification by the division, and not later than January 7 in any
1028 year. If expenditure reductions or cost containments are
1029 implemented, the Governor may implement a maximum amount of state
1030 share expenditure reductions to providers, of which hospitals will
1031 be responsible for twenty-five percent (25%) of provider
1032 reductions as follows: in fiscal year 2010, the maximum amount
1033 shall be Twenty-four Million Dollars (\$24,000,000.00); in fiscal
1034 year 2011, the maximum amount shall be Thirty-two Million Dollars
1035 (\$32,000,000.00); and in fiscal year 2012 and thereafter, the
1036 maximum amount shall be Forty Million Dollars (\$40,000,000.00).
1037 However, instead of implementing cuts, the hospital share shall be
1038 in the form of an additional assessment not to exceed Ten Million
1039 Dollars (\$10,000,000.00) as provided in Section
1040 43-13-145(4) (a) (ii). If Medicaid expenditures are projected to
1041 exceed the amount of funds appropriated to the division in any
1042 fiscal year in excess of the expenditure reductions to providers,



1043 then funds shall be transferred by the State Fiscal Officer from
1044 the Health Care Trust Fund into the Health Care Expendable Fund
1045 and to the Governor's Office, Division of Medicaid, from the
1046 Health Care Expendable Fund, in the amount and at such time as
1047 requested by the Governor to reconcile the deficit. If the cost
1048 containment measures described above have been implemented and
1049 there are insufficient funds in the Health Care Trust Fund to
1050 reconcile any remaining deficit in any fiscal year, the Governor
1051 shall institute any other additional cost containment measures on
1052 any program or programs authorized under this article to the
1053 extent allowed under federal law. Hospitals shall be responsible
1054 for twenty-five percent (25%) of any additional imposed provider
1055 cuts. However, instead of implementing hospital expenditure
1056 reductions, the hospital reductions shall be in the form of an
1057 additional assessment not to exceed twenty-five percent (25%) of
1058 provider expenditure reductions as provided in Section
1059 43-13-145(4)(a)(ii). It is the intent of the Legislature that the
1060 expenditures of the division during any fiscal year shall not
1061 exceed the amounts appropriated to the division for that fiscal
1062 year.

1063 (G) Notwithstanding any other provision of this article, it
1064 shall be the duty of each nursing facility, intermediate care
1065 facility for the mentally retarded, psychiatric residential
1066 treatment facility, and nursing facility for the severely disabled
1067 that is participating in the Medicaid program to keep and maintain
1068 books, documents and other records as prescribed by the Division
1069 of Medicaid in substantiation of its cost reports for a period of
1070 three (3) years after the date of submission to the Division of
1071 Medicaid of an original cost report, or three (3) years after the
1072 date of submission to the Division of Medicaid of an amended cost
1073 report.

1074 (H) (1) Notwithstanding any other provision of this
1075 article, the division shall not be authorized to implement any



1076 managed care program, coordinated care program, coordinated care
1077 organization, health maintenance organization or similar program
1078 in which services are paid for on a capitated basis, beyond the
1079 level, scope or location of the program as it existed on October
1080 1, 2008, until on or after January 1, 2010. Any managed care
1081 program or coordinated care program implemented by the division
1082 under this section shall be limited to a maximum of fifteen
1083 percent (15%) of all Medicaid beneficiaries, and any Medicaid
1084 beneficiary who is enrolled in the program shall have an annual
1085 window of at least thirty (30) days in length during which the
1086 beneficiary may disenroll from the program. In addition, any
1087 payments made to providers by a managed care organization,
1088 coordinated care organization, health maintenance organization or
1089 other similar organization under a managed care program or
1090 coordinated care program implemented by the division under this
1091 section shall be considered to be regular Medicaid payments for
1092 the purposes of calculating Medicare Upper Payment Limits (UPL)
1093 payments and Disproportionate Share Hospital (DSH) payments to
1094 hospitals. The division shall apply for any federal waiver or
1095 waivers necessary to implement a managed care program or
1096 coordinated care program that meets all of the requirements in
1097 this paragraph. If the division does not receive a federal waiver
1098 or waivers that authorizes it to implement a managed care program
1099 or coordinated care program that meets all of the requirements in
1100 this paragraph, then the division shall not be authorized to
1101 implement a managed care program or coordinated care program.

1102 (2) All health maintenance organizations, coordinated
1103 care organizations or other organizations paid for services on a
1104 capitated basis by the division under any managed care program or
1105 coordinated care program implemented by the division under this
1106 section shall reimburse all providers in those organizations at
1107 rates no lower than those provided under this section for
1108 beneficiaries who are not participating in those programs.



1109 (3) No health maintenance organization, coordinated
1110 care organization or other organization paid for services on a
1111 capitated basis by the division under any managed care program or
1112 coordinated care program implemented by the division under this
1113 section shall require its providers or beneficiaries to use any
1114 pharmacy that ships, mails or delivers prescription drugs or
1115 legend drugs or devices.

1116 (4) After a managed care program or coordinated care
1117 program is implemented by the division under this section, the
1118 PEER Committee shall conduct a comprehensive performance
1119 evaluation of the managed care program or coordinated care
1120 program, which shall include, but not be limited to, a
1121 determination of any cost savings to the division, quality of care
1122 to the beneficiaries, and access to care by the beneficiaries.
1123 The PEER Committee shall provide regular reports on the status of
1124 the managed care program or coordinated care program to the
1125 members of the Senate Public Health and Welfare Committee and the
1126 House Medicaid Committee, and shall complete the performance
1127 evaluation and provide it to the members of those committees not
1128 later than December 15, 2011. As a condition of participation in
1129 a managed care program or coordinated care program implemented by
1130 the division under this section, a provider must agree to provide
1131 any information that the PEER Committee requests to conduct the
1132 performance evaluation of the program, and all those providers
1133 shall fully cooperate with the PEER Committee in any request to
1134 provide information to the committee.

1135 (I) The division shall develop and publish reimbursement
1136 rates for each APR-DRG proposed by the division at least equal to
1137 the prevailing corresponding Medicare DRG rate or a closely
1138 related Medicare DRG rate, applying to each hospital, the
1139 applicable federal wage index being used by CMS for the hospital's
1140 geographic location, but the division shall not implement that
1141 rate schedule or APR-DRG methodology until after July 1, 2010.



1142 The PEER Committee shall study the benefits and liabilities of
1143 implementing an APR-DRG reimbursement rate schedule, and report
1144 its findings to the members of the Senate Public Health and
1145 Welfare Committee and the House Medicaid Committee on or before
1146 December 15, 2009.

1147 (J) There shall be no cuts in inpatient and outpatient
1148 hospital payments, or allowable days or volumes, as long as the
1149 hospital assessment provided in Section 43-13-145 is in effect.

1150 (K) This section shall stand repealed on July 1, 2013.

1151 **SECTION 14.** Section 41-7-191, Mississippi Code of 1972, is
1152 amended as follows:

1153 41-7-191. (1) No person shall engage in any of the
1154 following activities without obtaining the required certificate of
1155 need:

1156 (a) The construction, development or other
1157 establishment of a new health care facility, which establishment
1158 shall include the reopening of a health care facility that has
1159 ceased to operate for a period of sixty (60) months or more;

1160 (b) The relocation of a health care facility or portion
1161 thereof, or major medical equipment, unless such relocation of a
1162 health care facility or portion thereof, or major medical
1163 equipment, which does not involve a capital expenditure by or on
1164 behalf of a health care facility, is within five thousand two
1165 hundred eighty (5,280) feet from the main entrance of the health
1166 care facility;

1167 (c) Any change in the existing bed complement of any
1168 health care facility through the addition or conversion of any
1169 beds or the alteration, modernizing or refurbishing of any unit or
1170 department in which the beds may be located; however, if a health
1171 care facility has voluntarily delicensed some of its existing bed
1172 complement, it may later relicense some or all of its delicensed
1173 beds without the necessity of having to acquire a certificate of
1174 need. The State Department of Health shall maintain a record of



1175 the delicensing health care facility and its voluntarily
1176 delicensed beds and continue counting those beds as part of the
1177 state's total bed count for health care planning purposes. If a
1178 health care facility that has voluntarily delicensed some of its
1179 beds later desires to relicense some or all of its voluntarily
1180 delicensed beds, it shall notify the State Department of Health of
1181 its intent to increase the number of its licensed beds. The State
1182 Department of Health shall survey the health care facility within
1183 thirty (30) days of that notice and, if appropriate, issue the
1184 health care facility a new license reflecting the new contingent
1185 of beds. However, in no event may a health care facility that has
1186 voluntarily delicensed some of its beds be reissued a license to
1187 operate beds in excess of its bed count before the voluntary
1188 delicensure of some of its beds without seeking certificate of
1189 need approval;

1190 (d) Offering of the following health services if those
1191 services have not been provided on a regular basis by the proposed
1192 provider of such services within the period of twelve (12) months
1193 prior to the time such services would be offered:

- 1194 (i) Open-heart surgery services;
- 1195 (ii) Cardiac catheterization services;
- 1196 (iii) Comprehensive inpatient rehabilitation
1197 services;
- 1198 (iv) Licensed psychiatric services;
- 1199 (v) Licensed chemical dependency services;
- 1200 (vi) Radiation therapy services;
- 1201 (vii) Diagnostic imaging services of an invasive
1202 nature, i.e. invasive digital angiography;
- 1203 (viii) Nursing home care as defined in
1204 subparagraphs (iv), (vi) and (viii) of Section 41-7-173(h);
- 1205 (ix) Home health services;
- 1206 (x) Swing-bed services;
- 1207 (xi) Ambulatory surgical services;



- 1208 (xii) Magnetic resonance imaging services;
- 1209 (xiii) [Deleted]
- 1210 (xiv) Long-term care hospital services;
- 1211 (xv) Positron emission tomography (PET) services;

1212 (e) The relocation of one or more health services from
1213 one physical facility or site to another physical facility or
1214 site, unless such relocation, which does not involve a capital
1215 expenditure by or on behalf of a health care facility, (i) is to a
1216 physical facility or site within five thousand two hundred eighty
1217 (5,280) feet from the main entrance of the health care facility
1218 where the health care service is located, or (ii) is the result of
1219 an order of a court of appropriate jurisdiction or a result of
1220 pending litigation in such court, or by order of the State
1221 Department of Health, or by order of any other agency or legal
1222 entity of the state, the federal government, or any political
1223 subdivision of either, whose order is also approved by the State
1224 Department of Health;

1225 (f) The acquisition or otherwise control of any major
1226 medical equipment for the provision of medical services; provided,
1227 however, (i) the acquisition of any major medical equipment used
1228 only for research purposes, and (ii) the acquisition of major
1229 medical equipment to replace medical equipment for which a
1230 facility is already providing medical services and for which the
1231 State Department of Health has been notified before the date of
1232 such acquisition shall be exempt from this paragraph; an
1233 acquisition for less than fair market value must be reviewed, if
1234 the acquisition at fair market value would be subject to review;

1235 (g) Changes of ownership of existing health care
1236 facilities in which a notice of intent is not filed with the State
1237 Department of Health at least thirty (30) days prior to the date
1238 such change of ownership occurs, or a change in services or bed
1239 capacity as prescribed in paragraph (c) or (d) of this subsection
1240 as a result of the change of ownership; an acquisition for less



1241 than fair market value must be reviewed, if the acquisition at
1242 fair market value would be subject to review;

1243 (h) The change of ownership of any health care facility
1244 defined in subparagraphs (iv), (vi) and (viii) of Section
1245 41-7-173(h), in which a notice of intent as described in paragraph
1246 (g) has not been filed and if the Executive Director, Division of
1247 Medicaid, Office of the Governor, has not certified in writing
1248 that there will be no increase in allowable costs to Medicaid from
1249 revaluation of the assets or from increased interest and
1250 depreciation as a result of the proposed change of ownership;

1251 (i) Any activity described in paragraphs (a) through
1252 (h) if undertaken by any person if that same activity would
1253 require certificate of need approval if undertaken by a health
1254 care facility;

1255 (j) Any capital expenditure or deferred capital
1256 expenditure by or on behalf of a health care facility not covered
1257 by paragraphs (a) through (h);

1258 (k) The contracting of a health care facility as
1259 defined in subparagraphs (i) through (viii) of Section 41-7-173(h)
1260 to establish a home office, subunit, or branch office in the space
1261 operated as a health care facility through a formal arrangement
1262 with an existing health care facility as defined in subparagraph
1263 (ix) of Section 41-7-173(h);

1264 (l) The replacement or relocation of a health care
1265 facility designated as a critical access hospital shall be exempt
1266 from subsection (1) of this section so long as the critical access
1267 hospital complies with all applicable federal law and regulations
1268 regarding such replacement or relocation;

1269 (m) Reopening a health care facility that has ceased to
1270 operate for a period of sixty (60) months or more, which reopening
1271 requires a certificate of need for the establishment of a new
1272 health care facility.



1273 (2) The State Department of Health shall not grant approval
1274 for or issue a certificate of need to any person proposing the new
1275 construction of, addition to, or expansion of any health care
1276 facility defined in subparagraphs (iv) (skilled nursing facility)
1277 and (vi) (intermediate care facility) of Section 41-7-173(h) or
1278 the conversion of vacant hospital beds to provide skilled or
1279 intermediate nursing home care, except as hereinafter authorized:

1280 (a) The department may issue a certificate of need to
1281 any person proposing the new construction of any health care
1282 facility defined in subparagraphs (iv) and (vi) of Section
1283 41-7-173(h) as part of a life care retirement facility, in any
1284 county bordering on the Gulf of Mexico in which is located a
1285 National Aeronautics and Space Administration facility, not to
1286 exceed forty (40) beds. From and after July 1, 1999, there shall
1287 be no prohibition or restrictions on participation in the Medicaid
1288 program (Section 43-13-101 et seq.) for the beds in the health
1289 care facility that were authorized under this paragraph (a).

1290 (b) The department may issue certificates of need in
1291 Harrison County to provide skilled nursing home care for
1292 Alzheimer's disease patients and other patients, not to exceed one
1293 hundred fifty (150) beds. From and after July 1, 1999, there
1294 shall be no prohibition or restrictions on participation in the
1295 Medicaid program (Section 43-13-101 et seq.) for the beds in the
1296 nursing facilities that were authorized under this paragraph (b).

1297 (c) The department may issue a certificate of need for
1298 the addition to or expansion of any skilled nursing facility that
1299 is part of an existing continuing care retirement community
1300 located in Madison County, provided that the recipient of the
1301 certificate of need agrees in writing that the skilled nursing
1302 facility will not at any time participate in the Medicaid program
1303 (Section 43-13-101 et seq.) or admit or keep any patients in the
1304 skilled nursing facility who are participating in the Medicaid
1305 program. This written agreement by the recipient of the



1306 certificate of need shall be fully binding on any subsequent owner
1307 of the skilled nursing facility, if the ownership of the facility
1308 is transferred at any time after the issuance of the certificate
1309 of need. Agreement that the skilled nursing facility will not
1310 participate in the Medicaid program shall be a condition of the
1311 issuance of a certificate of need to any person under this
1312 paragraph (c), and if such skilled nursing facility at any time
1313 after the issuance of the certificate of need, regardless of the
1314 ownership of the facility, participates in the Medicaid program or
1315 admits or keeps any patients in the facility who are participating
1316 in the Medicaid program, the State Department of Health shall
1317 revoke the certificate of need, if it is still outstanding, and
1318 shall deny or revoke the license of the skilled nursing facility,
1319 at the time that the department determines, after a hearing
1320 complying with due process, that the facility has failed to comply
1321 with any of the conditions upon which the certificate of need was
1322 issued, as provided in this paragraph and in the written agreement
1323 by the recipient of the certificate of need. The total number of
1324 beds that may be authorized under the authority of this paragraph
1325 (c) shall not exceed sixty (60) beds.

1326 (d) The State Department of Health may issue a
1327 certificate of need to any hospital located in DeSoto County for
1328 the new construction of a skilled nursing facility, not to exceed
1329 one hundred twenty (120) beds, in DeSoto County. From and after
1330 July 1, 1999, there shall be no prohibition or restrictions on
1331 participation in the Medicaid program (Section 43-13-101 et seq.)
1332 for the beds in the nursing facility that were authorized under
1333 this paragraph (d).

1334 (e) The State Department of Health may issue a
1335 certificate of need for the construction of a nursing facility or
1336 the conversion of beds to nursing facility beds at a personal care
1337 facility for the elderly in Lowndes County that is owned and
1338 operated by a Mississippi nonprofit corporation, not to exceed



1339 sixty (60) beds. From and after July 1, 1999, there shall be no
1340 prohibition or restrictions on participation in the Medicaid
1341 program (Section 43-13-101 et seq.) for the beds in the nursing
1342 facility that were authorized under this paragraph (e).

1343 (f) The State Department of Health may issue a
1344 certificate of need for conversion of a county hospital facility
1345 in Itawamba County to a nursing facility, not to exceed sixty (60)
1346 beds, including any necessary construction, renovation or
1347 expansion. From and after July 1, 1999, there shall be no
1348 prohibition or restrictions on participation in the Medicaid
1349 program (Section 43-13-101 et seq.) for the beds in the nursing
1350 facility that were authorized under this paragraph (f).

1351 (g) The State Department of Health may issue a
1352 certificate of need for the construction or expansion of nursing
1353 facility beds or the conversion of other beds to nursing facility
1354 beds in either Hinds, Madison or Rankin County, not to exceed
1355 sixty (60) beds. From and after July 1, 1999, there shall be no
1356 prohibition or restrictions on participation in the Medicaid
1357 program (Section 43-13-101 et seq.) for the beds in the nursing
1358 facility that were authorized under this paragraph (g).

1359 (h) The State Department of Health may issue a
1360 certificate of need for the construction or expansion of nursing
1361 facility beds or the conversion of other beds to nursing facility
1362 beds in either Hancock, Harrison or Jackson County, not to exceed
1363 sixty (60) beds. From and after July 1, 1999, there shall be no
1364 prohibition or restrictions on participation in the Medicaid
1365 program (Section 43-13-101 et seq.) for the beds in the facility
1366 that were authorized under this paragraph (h).

1367 (i) The department may issue a certificate of need for
1368 the new construction of a skilled nursing facility in Leake
1369 County, provided that the recipient of the certificate of need
1370 agrees in writing that the skilled nursing facility will not at
1371 any time participate in the Medicaid program (Section 43-13-101 et



1372 seq.) or admit or keep any patients in the skilled nursing
1373 facility who are participating in the Medicaid program. This
1374 written agreement by the recipient of the certificate of need
1375 shall be fully binding on any subsequent owner of the skilled
1376 nursing facility, if the ownership of the facility is transferred
1377 at any time after the issuance of the certificate of need.
1378 Agreement that the skilled nursing facility will not participate
1379 in the Medicaid program shall be a condition of the issuance of a
1380 certificate of need to any person under this paragraph (i), and if
1381 such skilled nursing facility at any time after the issuance of
1382 the certificate of need, regardless of the ownership of the
1383 facility, participates in the Medicaid program or admits or keeps
1384 any patients in the facility who are participating in the Medicaid
1385 program, the State Department of Health shall revoke the
1386 certificate of need, if it is still outstanding, and shall deny or
1387 revoke the license of the skilled nursing facility, at the time
1388 that the department determines, after a hearing complying with due
1389 process, that the facility has failed to comply with any of the
1390 conditions upon which the certificate of need was issued, as
1391 provided in this paragraph and in the written agreement by the
1392 recipient of the certificate of need. The provision of Section
1393 43-7-193(1) regarding substantial compliance of the projection of
1394 need as reported in the current State Health Plan is waived for
1395 the purposes of this paragraph. The total number of nursing
1396 facility beds that may be authorized by any certificate of need
1397 issued under this paragraph (i) shall not exceed sixty (60) beds.
1398 If the skilled nursing facility authorized by the certificate of
1399 need issued under this paragraph is not constructed and fully
1400 operational within eighteen (18) months after July 1, 1994, the
1401 State Department of Health, after a hearing complying with due
1402 process, shall revoke the certificate of need, if it is still
1403 outstanding, and shall not issue a license for the skilled nursing



1404 facility at any time after the expiration of the eighteen-month
1405 period.

1406 (j) The department may issue certificates of need to
1407 allow any existing freestanding long-term care facility in
1408 Tishomingo County and Hancock County that on July 1, 1995, is
1409 licensed with fewer than sixty (60) beds. For the purposes of
1410 this paragraph (j), the provisions of Section 41-7-193(1)
1411 requiring substantial compliance with the projection of need as
1412 reported in the current State Health Plan are waived. From and
1413 after July 1, 1999, there shall be no prohibition or restrictions
1414 on participation in the Medicaid program (Section 43-13-101 et
1415 seq.) for the beds in the long-term care facilities that were
1416 authorized under this paragraph (j).

1417 (k) The department may issue a certificate of need for
1418 the construction of a nursing facility at a continuing care
1419 retirement community in Lowndes County. The total number of beds
1420 that may be authorized under the authority of this paragraph (k)
1421 shall not exceed sixty (60) beds. From and after July 1, 2001,
1422 the prohibition on the facility participating in the Medicaid
1423 program (Section 43-13-101 et seq.) that was a condition of
1424 issuance of the certificate of need under this paragraph (k) shall
1425 be revised as follows: The nursing facility may participate in
1426 the Medicaid program from and after July 1, 2001, if the owner of
1427 the facility on July 1, 2001, agrees in writing that no more than
1428 thirty (30) of the beds at the facility will be certified for
1429 participation in the Medicaid program, and that no claim will be
1430 submitted for Medicaid reimbursement for more than thirty (30)
1431 patients in the facility in any month or for any patient in the
1432 facility who is in a bed that is not Medicaid-certified. This
1433 written agreement by the owner of the facility shall be a
1434 condition of licensure of the facility, and the agreement shall be
1435 fully binding on any subsequent owner of the facility if the
1436 ownership of the facility is transferred at any time after July 1,



1437 2001. After this written agreement is executed, the Division of
1438 Medicaid and the State Department of Health shall not certify more
1439 than thirty (30) of the beds in the facility for participation in
1440 the Medicaid program. If the facility violates the terms of the
1441 written agreement by admitting or keeping in the facility on a
1442 regular or continuing basis more than thirty (30) patients who are
1443 participating in the Medicaid program, the State Department of
1444 Health shall revoke the license of the facility, at the time that
1445 the department determines, after a hearing complying with due
1446 process, that the facility has violated the written agreement.

1447 (l) Provided that funds are specifically appropriated
1448 therefor by the Legislature, the department may issue a
1449 certificate of need to a rehabilitation hospital in Hinds County
1450 for the construction of a sixty-bed long-term care nursing
1451 facility dedicated to the care and treatment of persons with
1452 severe disabilities including persons with spinal cord and
1453 closed-head injuries and ventilator dependent patients. The
1454 provisions of Section 41-7-193(1) regarding substantial compliance
1455 with projection of need as reported in the current State Health
1456 Plan are hereby waived for the purpose of this paragraph.

1457 (m) The State Department of Health may issue a
1458 certificate of need to a county-owned hospital in the Second
1459 Judicial District of Panola County for the conversion of not more
1460 than seventy-two (72) hospital beds to nursing facility beds,
1461 provided that the recipient of the certificate of need agrees in
1462 writing that none of the beds at the nursing facility will be
1463 certified for participation in the Medicaid program (Section
1464 43-13-101 et seq.), and that no claim will be submitted for
1465 Medicaid reimbursement in the nursing facility in any day or for
1466 any patient in the nursing facility. This written agreement by
1467 the recipient of the certificate of need shall be a condition of
1468 the issuance of the certificate of need under this paragraph, and
1469 the agreement shall be fully binding on any subsequent owner of



1470 the nursing facility if the ownership of the nursing facility is
1471 transferred at any time after the issuance of the certificate of
1472 need. After this written agreement is executed, the Division of
1473 Medicaid and the State Department of Health shall not certify any
1474 of the beds in the nursing facility for participation in the
1475 Medicaid program. If the nursing facility violates the terms of
1476 the written agreement by admitting or keeping in the nursing
1477 facility on a regular or continuing basis any patients who are
1478 participating in the Medicaid program, the State Department of
1479 Health shall revoke the license of the nursing facility, at the
1480 time that the department determines, after a hearing complying
1481 with due process, that the nursing facility has violated the
1482 condition upon which the certificate of need was issued, as
1483 provided in this paragraph and in the written agreement. If the
1484 certificate of need authorized under this paragraph is not issued
1485 within twelve (12) months after July 1, 2001, the department shall
1486 deny the application for the certificate of need and shall not
1487 issue the certificate of need at any time after the twelve-month
1488 period, unless the issuance is contested. If the certificate of
1489 need is issued and substantial construction of the nursing
1490 facility beds has not commenced within eighteen (18) months after
1491 July 1, 2001, the State Department of Health, after a hearing
1492 complying with due process, shall revoke the certificate of need
1493 if it is still outstanding, and the department shall not issue a
1494 license for the nursing facility at any time after the
1495 eighteen-month period. Provided, however, that if the issuance of
1496 the certificate of need is contested, the department shall require
1497 substantial construction of the nursing facility beds within six
1498 (6) months after final adjudication on the issuance of the
1499 certificate of need.

1500 (n) The department may issue a certificate of need for
1501 the new construction, addition or conversion of skilled nursing
1502 facility beds in Madison County, provided that the recipient of



1503 the certificate of need agrees in writing that the skilled nursing
1504 facility will not at any time participate in the Medicaid program
1505 (Section 43-13-101 et seq.) or admit or keep any patients in the
1506 skilled nursing facility who are participating in the Medicaid
1507 program. This written agreement by the recipient of the
1508 certificate of need shall be fully binding on any subsequent owner
1509 of the skilled nursing facility, if the ownership of the facility
1510 is transferred at any time after the issuance of the certificate
1511 of need. Agreement that the skilled nursing facility will not
1512 participate in the Medicaid program shall be a condition of the
1513 issuance of a certificate of need to any person under this
1514 paragraph (n), and if such skilled nursing facility at any time
1515 after the issuance of the certificate of need, regardless of the
1516 ownership of the facility, participates in the Medicaid program or
1517 admits or keeps any patients in the facility who are participating
1518 in the Medicaid program, the State Department of Health shall
1519 revoke the certificate of need, if it is still outstanding, and
1520 shall deny or revoke the license of the skilled nursing facility,
1521 at the time that the department determines, after a hearing
1522 complying with due process, that the facility has failed to comply
1523 with any of the conditions upon which the certificate of need was
1524 issued, as provided in this paragraph and in the written agreement
1525 by the recipient of the certificate of need. The total number of
1526 nursing facility beds that may be authorized by any certificate of
1527 need issued under this paragraph (n) shall not exceed sixty (60)
1528 beds. If the certificate of need authorized under this paragraph
1529 is not issued within twelve (12) months after July 1, 1998, the
1530 department shall deny the application for the certificate of need
1531 and shall not issue the certificate of need at any time after the
1532 twelve-month period, unless the issuance is contested. If the
1533 certificate of need is issued and substantial construction of the
1534 nursing facility beds has not commenced within eighteen (18)
1535 months after July 1, 1998, the State Department of Health, after a



1536 hearing complying with due process, shall revoke the certificate
1537 of need if it is still outstanding, and the department shall not
1538 issue a license for the nursing facility at any time after the
1539 eighteen-month period. Provided, however, that if the issuance of
1540 the certificate of need is contested, the department shall require
1541 substantial construction of the nursing facility beds within six
1542 (6) months after final adjudication on the issuance of the
1543 certificate of need.

1544 (o) The department may issue a certificate of need for
1545 the new construction, addition or conversion of skilled nursing
1546 facility beds in Leake County, provided that the recipient of the
1547 certificate of need agrees in writing that the skilled nursing
1548 facility will not at any time participate in the Medicaid program
1549 (Section 43-13-101 et seq.) or admit or keep any patients in the
1550 skilled nursing facility who are participating in the Medicaid
1551 program. This written agreement by the recipient of the
1552 certificate of need shall be fully binding on any subsequent owner
1553 of the skilled nursing facility, if the ownership of the facility
1554 is transferred at any time after the issuance of the certificate
1555 of need. Agreement that the skilled nursing facility will not
1556 participate in the Medicaid program shall be a condition of the
1557 issuance of a certificate of need to any person under this
1558 paragraph (o), and if such skilled nursing facility at any time
1559 after the issuance of the certificate of need, regardless of the
1560 ownership of the facility, participates in the Medicaid program or
1561 admits or keeps any patients in the facility who are participating
1562 in the Medicaid program, the State Department of Health shall
1563 revoke the certificate of need, if it is still outstanding, and
1564 shall deny or revoke the license of the skilled nursing facility,
1565 at the time that the department determines, after a hearing
1566 complying with due process, that the facility has failed to comply
1567 with any of the conditions upon which the certificate of need was
1568 issued, as provided in this paragraph and in the written agreement



1569 by the recipient of the certificate of need. The total number of
1570 nursing facility beds that may be authorized by any certificate of
1571 need issued under this paragraph (o) shall not exceed sixty (60)
1572 beds. If the certificate of need authorized under this paragraph
1573 is not issued within twelve (12) months after July 1, 2001, the
1574 department shall deny the application for the certificate of need
1575 and shall not issue the certificate of need at any time after the
1576 twelve-month period, unless the issuance is contested. If the
1577 certificate of need is issued and substantial construction of the
1578 nursing facility beds has not commenced within eighteen (18)
1579 months after July 1, 2001, the State Department of Health, after a
1580 hearing complying with due process, shall revoke the certificate
1581 of need if it is still outstanding, and the department shall not
1582 issue a license for the nursing facility at any time after the
1583 eighteen-month period. Provided, however, that if the issuance of
1584 the certificate of need is contested, the department shall require
1585 substantial construction of the nursing facility beds within six
1586 (6) months after final adjudication on the issuance of the
1587 certificate of need.

1588 (p) The department may issue a certificate of need for
1589 the construction of a municipally owned nursing facility within
1590 the Town of Belmont in Tishomingo County, not to exceed sixty (60)
1591 beds, provided that the recipient of the certificate of need
1592 agrees in writing that the skilled nursing facility will not at
1593 any time participate in the Medicaid program (Section 43-13-101 et
1594 seq.) or admit or keep any patients in the skilled nursing
1595 facility who are participating in the Medicaid program. This
1596 written agreement by the recipient of the certificate of need
1597 shall be fully binding on any subsequent owner of the skilled
1598 nursing facility, if the ownership of the facility is transferred
1599 at any time after the issuance of the certificate of need.

1600 Agreement that the skilled nursing facility will not participate
1601 in the Medicaid program shall be a condition of the issuance of a



1602 certificate of need to any person under this paragraph (p), and if
1603 such skilled nursing facility at any time after the issuance of
1604 the certificate of need, regardless of the ownership of the
1605 facility, participates in the Medicaid program or admits or keeps
1606 any patients in the facility who are participating in the Medicaid
1607 program, the State Department of Health shall revoke the
1608 certificate of need, if it is still outstanding, and shall deny or
1609 revoke the license of the skilled nursing facility, at the time
1610 that the department determines, after a hearing complying with due
1611 process, that the facility has failed to comply with any of the
1612 conditions upon which the certificate of need was issued, as
1613 provided in this paragraph and in the written agreement by the
1614 recipient of the certificate of need. The provision of Section
1615 43-7-193(1) regarding substantial compliance of the projection of
1616 need as reported in the current State Health Plan is waived for
1617 the purposes of this paragraph. If the certificate of need
1618 authorized under this paragraph is not issued within twelve (12)
1619 months after July 1, 1998, the department shall deny the
1620 application for the certificate of need and shall not issue the
1621 certificate of need at any time after the twelve-month period,
1622 unless the issuance is contested. If the certificate of need is
1623 issued and substantial construction of the nursing facility beds
1624 has not commenced within eighteen (18) months after July 1, 1998,
1625 the State Department of Health, after a hearing complying with due
1626 process, shall revoke the certificate of need if it is still
1627 outstanding, and the department shall not issue a license for the
1628 nursing facility at any time after the eighteen-month period.
1629 Provided, however, that if the issuance of the certificate of need
1630 is contested, the department shall require substantial
1631 construction of the nursing facility beds within six (6) months
1632 after final adjudication on the issuance of the certificate of
1633 need.



1634 (q) (i) Beginning on July 1, 1999, the State
1635 Department of Health shall issue certificates of need during each
1636 of the next four (4) fiscal years for the construction or
1637 expansion of nursing facility beds or the conversion of other beds
1638 to nursing facility beds in each county in the state having a need
1639 for fifty (50) or more additional nursing facility beds, as shown
1640 in the fiscal year 1999 State Health Plan, in the manner provided
1641 in this paragraph (q). The total number of nursing facility beds
1642 that may be authorized by any certificate of need authorized under
1643 this paragraph (q) shall not exceed sixty (60) beds.

1644 (ii) Subject to the provisions of subparagraph
1645 (v), during each of the next four (4) fiscal years, the department
1646 shall issue six (6) certificates of need for new nursing facility
1647 beds, as follows: During fiscal years 2000, 2001 and 2002, one
1648 (1) certificate of need shall be issued for new nursing facility
1649 beds in the county in each of the four (4) Long-Term Care Planning
1650 Districts designated in the fiscal year 1999 State Health Plan
1651 that has the highest need in the district for those beds; and two
1652 (2) certificates of need shall be issued for new nursing facility
1653 beds in the two (2) counties from the state at large that have the
1654 highest need in the state for those beds, when considering the
1655 need on a statewide basis and without regard to the Long-Term Care
1656 Planning Districts in which the counties are located. During
1657 fiscal year 2003, one (1) certificate of need shall be issued for
1658 new nursing facility beds in any county having a need for fifty
1659 (50) or more additional nursing facility beds, as shown in the
1660 fiscal year 1999 State Health Plan, that has not received a
1661 certificate of need under this paragraph (q) during the three (3)
1662 previous fiscal years. During fiscal year 2000, in addition to
1663 the six (6) certificates of need authorized in this subparagraph,
1664 the department also shall issue a certificate of need for new
1665 nursing facility beds in Amite County and a certificate of need
1666 for new nursing facility beds in Carroll County.



1667 (iii) Subject to the provisions of subparagraph
1668 (v), the certificate of need issued under subparagraph (ii) for
1669 nursing facility beds in each Long-Term Care Planning District
1670 during each fiscal year shall first be available for nursing
1671 facility beds in the county in the district having the highest
1672 need for those beds, as shown in the fiscal year 1999 State Health
1673 Plan. If there are no applications for a certificate of need for
1674 nursing facility beds in the county having the highest need for
1675 those beds by the date specified by the department, then the
1676 certificate of need shall be available for nursing facility beds
1677 in other counties in the district in descending order of the need
1678 for those beds, from the county with the second highest need to
1679 the county with the lowest need, until an application is received
1680 for nursing facility beds in an eligible county in the district.

1681 (iv) Subject to the provisions of subparagraph
1682 (v), the certificate of need issued under subparagraph (ii) for
1683 nursing facility beds in the two (2) counties from the state at
1684 large during each fiscal year shall first be available for nursing
1685 facility beds in the two (2) counties that have the highest need
1686 in the state for those beds, as shown in the fiscal year 1999
1687 State Health Plan, when considering the need on a statewide basis
1688 and without regard to the Long-Term Care Planning Districts in
1689 which the counties are located. If there are no applications for
1690 a certificate of need for nursing facility beds in either of the
1691 two (2) counties having the highest need for those beds on a
1692 statewide basis by the date specified by the department, then the
1693 certificate of need shall be available for nursing facility beds
1694 in other counties from the state at large in descending order of
1695 the need for those beds on a statewide basis, from the county with
1696 the second highest need to the county with the lowest need, until
1697 an application is received for nursing facility beds in an
1698 eligible county from the state at large.



1699 (v) If a certificate of need is authorized to be
1700 issued under this paragraph (q) for nursing facility beds in a
1701 county on the basis of the need in the Long-Term Care Planning
1702 District during any fiscal year of the four-year period, a
1703 certificate of need shall not also be available under this
1704 paragraph (q) for additional nursing facility beds in that county
1705 on the basis of the need in the state at large, and that county
1706 shall be excluded in determining which counties have the highest
1707 need for nursing facility beds in the state at large for that
1708 fiscal year. After a certificate of need has been issued under
1709 this paragraph (q) for nursing facility beds in a county during
1710 any fiscal year of the four-year period, a certificate of need
1711 shall not be available again under this paragraph (q) for
1712 additional nursing facility beds in that county during the
1713 four-year period, and that county shall be excluded in determining
1714 which counties have the highest need for nursing facility beds in
1715 succeeding fiscal years.

1716 (vi) If more than one (1) application is made for
1717 a certificate of need for nursing home facility beds available
1718 under this paragraph (q), in Yalobusha, Newton or Tallahatchie
1719 County, and one (1) of the applicants is a county-owned hospital
1720 located in the county where the nursing facility beds are
1721 available, the department shall give priority to the county-owned
1722 hospital in granting the certificate of need if the following
1723 conditions are met:

1724 1. The county-owned hospital fully meets all
1725 applicable criteria and standards required to obtain a certificate
1726 of need for the nursing facility beds; and

1727 2. The county-owned hospital's qualifications
1728 for the certificate of need, as shown in its application and as
1729 determined by the department, are at least equal to the
1730 qualifications of the other applicants for the certificate of
1731 need.



1732 (r) (i) Beginning on July 1, 1999, the State
1733 Department of Health shall issue certificates of need during each
1734 of the next two (2) fiscal years for the construction or expansion
1735 of nursing facility beds or the conversion of other beds to
1736 nursing facility beds in each of the four (4) Long-Term Care
1737 Planning Districts designated in the fiscal year 1999 State Health
1738 Plan, to provide care exclusively to patients with Alzheimer's
1739 disease.

1740 (ii) Not more than twenty (20) beds may be
1741 authorized by any certificate of need issued under this paragraph
1742 (r), and not more than a total of sixty (60) beds may be
1743 authorized in any Long-Term Care Planning District by all
1744 certificates of need issued under this paragraph (r). However,
1745 the total number of beds that may be authorized by all
1746 certificates of need issued under this paragraph (r) during any
1747 fiscal year shall not exceed one hundred twenty (120) beds, and
1748 the total number of beds that may be authorized in any Long-Term
1749 Care Planning District during any fiscal year shall not exceed
1750 forty (40) beds. Of the certificates of need that are issued for
1751 each Long-Term Care Planning District during the next two (2)
1752 fiscal years, at least one (1) shall be issued for beds in the
1753 northern part of the district, at least one (1) shall be issued
1754 for beds in the central part of the district, and at least one (1)
1755 shall be issued for beds in the southern part of the district.

1756 (iii) The State Department of Health, in
1757 consultation with the Department of Mental Health and the Division
1758 of Medicaid, shall develop and prescribe the staffing levels,
1759 space requirements and other standards and requirements that must
1760 be met with regard to the nursing facility beds authorized under
1761 this paragraph (r) to provide care exclusively to patients with
1762 Alzheimer's disease.

1763 (s) The State Department of Health may issue a
1764 certificate of need to a nonprofit skilled nursing facility using



1765 the Green House model of skilled nursing care and located in Yazoo
1766 City, Yazoo County, Mississippi, for the construction, expansion
1767 or conversion of not more than nineteen (19) nursing facility
1768 beds. For purposes of this paragraph (s), the provisions of
1769 Section 41-7-193(1) requiring substantial compliance with the
1770 projection of need as reported in the current State Health Plan
1771 and the provisions of Section 41-7-197 requiring a formal
1772 certificate of need hearing process are waived. There shall be no
1773 prohibition or restrictions on participation in the Medicaid
1774 program for the person receiving the certificate of need
1775 authorized under this paragraph (s).

1776 (t) The State Department of Health shall issue
1777 certificates of need to the owner of a nursing facility in
1778 operation at the time of Hurricane Katrina in Hancock County that
1779 was not operational on December 31, 2005, because of damage
1780 sustained from Hurricane Katrina to authorize the following: (i)
1781 the construction of a new nursing facility in Harrison County;
1782 (ii) the relocation of forty-nine (49) nursing facility beds from
1783 the Hancock County facility to the new Harrison County facility;
1784 (iii) the establishment of not more than twenty (20) non-Medicaid
1785 nursing facility beds at the Hancock County facility; and (iv) the
1786 establishment of not more than twenty (20) non-Medicaid beds at
1787 the new Harrison County facility. The certificates of need that
1788 authorize the non-Medicaid nursing facility beds under
1789 subparagraphs (iii) and (iv) of this paragraph (t) shall be
1790 subject to the following conditions: The owner of the Hancock
1791 County facility and the new Harrison County facility must agree in
1792 writing that no more than fifty (50) of the beds at the Hancock
1793 County facility and no more than forty-nine (49) of the beds at
1794 the Harrison County facility will be certified for participation
1795 in the Medicaid program, and that no claim will be submitted for
1796 Medicaid reimbursement for more than fifty (50) patients in the
1797 Hancock County facility in any month, or for more than forty-nine



1798 (49) patients in the Harrison County facility in any month, or for
1799 any patient in either facility who is in a bed that is not
1800 Medicaid-certified. This written agreement by the owner of the
1801 nursing facilities shall be a condition of the issuance of the
1802 certificates of need under this paragraph (t), and the agreement
1803 shall be fully binding on any later owner or owners of either
1804 facility if the ownership of either facility is transferred at any
1805 time after the certificates of need are issued. After this
1806 written agreement is executed, the Division of Medicaid and the
1807 State Department of Health shall not certify more than fifty (50)
1808 of the beds at the Hancock County facility or more than forty-nine
1809 (49) of the beds at the Harrison County facility for participation
1810 in the Medicaid program. If the Hancock County facility violates
1811 the terms of the written agreement by admitting or keeping in the
1812 facility on a regular or continuing basis more than fifty (50)
1813 patients who are participating in the Medicaid program, or if the
1814 Harrison County facility violates the terms of the written
1815 agreement by admitting or keeping in the facility on a regular or
1816 continuing basis more than forty-nine (49) patients who are
1817 participating in the Medicaid program, the State Department of
1818 Health shall revoke the license of the facility that is in
1819 violation of the agreement, at the time that the department
1820 determines, after a hearing complying with due process, that the
1821 facility has violated the agreement.

1822 (u) The State Department of Health shall issue a
1823 certificate of need to a nonprofit venture for the establishment,
1824 construction and operation of a skilled nursing facility of not
1825 more than sixty (60) beds to provide skilled nursing care for
1826 ventilator dependent or otherwise medically dependent pediatric
1827 patients who require medical and nursing care or rehabilitation
1828 services to be located in a county in which an academic medical
1829 center and a children's hospital are located, and for any
1830 construction and for the acquisition of equipment related to those



1831 beds. The facility shall be authorized to keep such ventilator
1832 dependent or otherwise medically dependent pediatric patients
1833 beyond age twenty-one (21) in accordance with regulations of the
1834 State Board of Health. For purposes of this paragraph (u), the
1835 provisions of Section 41-7-193(1) requiring substantial compliance
1836 with the projection of need as reported in the current State
1837 Health Plan are waived, and the provisions of Section 41-7-197
1838 requiring a formal certificate of need hearing process are waived.
1839 The beds authorized by this paragraph shall be counted as
1840 pediatric skilled nursing facility beds for health planning
1841 purposes under Section 41-7-171 et seq. There shall be no
1842 prohibition of or restrictions on participation in the Medicaid
1843 program for the person receiving the certificate of need
1844 authorized by this paragraph.

1845 (3) The State Department of Health may grant approval for
1846 and issue certificates of need to any person proposing the new
1847 construction of, addition to, conversion of beds of or expansion
1848 of any health care facility defined in subparagraph (x)
1849 (psychiatric residential treatment facility) of Section
1850 41-7-173(h). The total number of beds which may be authorized by
1851 such certificates of need shall not exceed three hundred
1852 thirty-four (334) beds for the entire state.

1853 (a) Of the total number of beds authorized under this
1854 subsection, the department shall issue a certificate of need to a
1855 privately owned psychiatric residential treatment facility in
1856 Simpson County for the conversion of sixteen (16) intermediate
1857 care facility for the mentally retarded (ICF-MR) beds to
1858 psychiatric residential treatment facility beds, provided that
1859 facility agrees in writing that the facility shall give priority
1860 for the use of those sixteen (16) beds to Mississippi residents
1861 who are presently being treated in out-of-state facilities.

1862 (b) Of the total number of beds authorized under this
1863 subsection, the department may issue a certificate or certificates



1864 of need for the construction or expansion of psychiatric
1865 residential treatment facility beds or the conversion of other
1866 beds to psychiatric residential treatment facility beds in Warren
1867 County, not to exceed sixty (60) psychiatric residential treatment
1868 facility beds, provided that the facility agrees in writing that
1869 no more than thirty (30) of the beds at the psychiatric
1870 residential treatment facility will be certified for participation
1871 in the Medicaid program (Section 43-13-101 et seq.) for the use of
1872 any patients other than those who are participating only in the
1873 Medicaid program of another state, and that no claim will be
1874 submitted to the Division of Medicaid for Medicaid reimbursement
1875 for more than thirty (30) patients in the psychiatric residential
1876 treatment facility in any day or for any patient in the
1877 psychiatric residential treatment facility who is in a bed that is
1878 not Medicaid-certified. This written agreement by the recipient
1879 of the certificate of need shall be a condition of the issuance of
1880 the certificate of need under this paragraph, and the agreement
1881 shall be fully binding on any subsequent owner of the psychiatric
1882 residential treatment facility if the ownership of the facility is
1883 transferred at any time after the issuance of the certificate of
1884 need. After this written agreement is executed, the Division of
1885 Medicaid and the State Department of Health shall not certify more
1886 than thirty (30) of the beds in the psychiatric residential
1887 treatment facility for participation in the Medicaid program for
1888 the use of any patients other than those who are participating
1889 only in the Medicaid program of another state. If the psychiatric
1890 residential treatment facility violates the terms of the written
1891 agreement by admitting or keeping in the facility on a regular or
1892 continuing basis more than thirty (30) patients who are
1893 participating in the Mississippi Medicaid program, the State
1894 Department of Health shall revoke the license of the facility, at
1895 the time that the department determines, after a hearing complying
1896 with due process, that the facility has violated the condition



1897 upon which the certificate of need was issued, as provided in this
1898 paragraph and in the written agreement.

1899 The State Department of Health, on or before July 1, 2002,
1900 shall transfer the certificate of need authorized under the
1901 authority of this paragraph (b), or reissue the certificate of
1902 need if it has expired, to River Region Health System.

1903 (c) Of the total number of beds authorized under this
1904 subsection, the department shall issue a certificate of need to a
1905 hospital currently operating Medicaid-certified acute psychiatric
1906 beds for adolescents in DeSoto County, for the establishment of a
1907 forty-bed psychiatric residential treatment facility in DeSoto
1908 County, provided that the hospital agrees in writing (i) that the
1909 hospital shall give priority for the use of those forty (40) beds
1910 to Mississippi residents who are presently being treated in
1911 out-of-state facilities, and (ii) that no more than fifteen (15)
1912 of the beds at the psychiatric residential treatment facility will
1913 be certified for participation in the Medicaid program (Section
1914 43-13-101 et seq.), and that no claim will be submitted for
1915 Medicaid reimbursement for more than fifteen (15) patients in the
1916 psychiatric residential treatment facility in any day or for any
1917 patient in the psychiatric residential treatment facility who is
1918 in a bed that is not Medicaid-certified. This written agreement
1919 by the recipient of the certificate of need shall be a condition
1920 of the issuance of the certificate of need under this paragraph,
1921 and the agreement shall be fully binding on any subsequent owner
1922 of the psychiatric residential treatment facility if the ownership
1923 of the facility is transferred at any time after the issuance of
1924 the certificate of need. After this written agreement is
1925 executed, the Division of Medicaid and the State Department of
1926 Health shall not certify more than fifteen (15) of the beds in the
1927 psychiatric residential treatment facility for participation in
1928 the Medicaid program. If the psychiatric residential treatment
1929 facility violates the terms of the written agreement by admitting



1930 or keeping in the facility on a regular or continuing basis more
1931 than fifteen (15) patients who are participating in the Medicaid
1932 program, the State Department of Health shall revoke the license
1933 of the facility, at the time that the department determines, after
1934 a hearing complying with due process, that the facility has
1935 violated the condition upon which the certificate of need was
1936 issued, as provided in this paragraph and in the written
1937 agreement.

1938 (d) Of the total number of beds authorized under this
1939 subsection, the department may issue a certificate or certificates
1940 of need for the construction or expansion of psychiatric
1941 residential treatment facility beds or the conversion of other
1942 beds to psychiatric treatment facility beds, not to exceed thirty
1943 (30) psychiatric residential treatment facility beds, in either
1944 Alcorn, Tishomingo, Prentiss, Lee, Itawamba, Monroe, Chickasaw,
1945 Pontotoc, Calhoun, Lafayette, Union, Benton or Tippah County.

1946 (e) Of the total number of beds authorized under this
1947 subsection (3) the department shall issue a certificate of need to
1948 a privately owned, nonprofit psychiatric residential treatment
1949 facility in Hinds County for an eight-bed expansion of the
1950 facility, provided that the facility agrees in writing that the
1951 facility shall give priority for the use of those eight (8) beds
1952 to Mississippi residents who are presently being treated in
1953 out-of-state facilities.

1954 (f) The department shall issue a certificate of need to
1955 a one-hundred-thirty-four-bed specialty hospital located on
1956 twenty-nine and forty-four one-hundredths (29.44) commercial acres
1957 at 5900 Highway 39 North in Meridian (Lauderdale County),
1958 Mississippi, for the addition, construction or expansion of
1959 child/adolescent psychiatric residential treatment facility beds
1960 in Lauderdale County. As a condition of issuance of the
1961 certificate of need under this paragraph, the facility shall give
1962 priority in admissions to the child/adolescent psychiatric



1963 residential treatment facility beds authorized under this
1964 paragraph to patients who otherwise would require out-of-state
1965 placement. The Division of Medicaid, in conjunction with the
1966 Department of Human Services, shall furnish the facility a list of
1967 all out-of-state patients on a quarterly basis. Furthermore,
1968 notice shall also be provided to the parent, custodial parent or
1969 guardian of each out-of-state patient notifying them of the
1970 priority status granted by this paragraph. For purposes of this
1971 paragraph, the provisions of Section 41-7-193(1) requiring
1972 substantial compliance with the projection of need as reported in
1973 the current State Health Plan are waived. The total number of
1974 child/adolescent psychiatric residential treatment facility beds
1975 that may be authorized under the authority of this paragraph shall
1976 be sixty (60) beds. There shall be no prohibition or restrictions
1977 on participation in the Medicaid program (Section 43-13-101 et
1978 seq.) for the person receiving the certificate of need authorized
1979 under this paragraph or for the beds converted pursuant to the
1980 authority of that certificate of need.

1981 (4) (a) From and after July 1, 1993, the department shall
1982 not issue a certificate of need to any person for the new
1983 construction of any hospital, psychiatric hospital or chemical
1984 dependency hospital that will contain any child/adolescent
1985 psychiatric or child/adolescent chemical dependency beds, or for
1986 the conversion of any other health care facility to a hospital,
1987 psychiatric hospital or chemical dependency hospital that will
1988 contain any child/adolescent psychiatric or child/adolescent
1989 chemical dependency beds, or for the addition of any
1990 child/adolescent psychiatric or child/adolescent chemical
1991 dependency beds in any hospital, psychiatric hospital or chemical
1992 dependency hospital, or for the conversion of any beds of another
1993 category in any hospital, psychiatric hospital or chemical
1994 dependency hospital to child/adolescent psychiatric or



1995 child/adolescent chemical dependency beds, except as hereinafter
1996 authorized:

1997 (i) The department may issue certificates of need
1998 to any person for any purpose described in this subsection,
1999 provided that the hospital, psychiatric hospital or chemical
2000 dependency hospital does not participate in the Medicaid program
2001 (Section 43-13-101 et seq.) at the time of the application for the
2002 certificate of need and the owner of the hospital, psychiatric
2003 hospital or chemical dependency hospital agrees in writing that
2004 the hospital, psychiatric hospital or chemical dependency hospital
2005 will not at any time participate in the Medicaid program or admit
2006 or keep any patients who are participating in the Medicaid program
2007 in the hospital, psychiatric hospital or chemical dependency
2008 hospital. This written agreement by the recipient of the
2009 certificate of need shall be fully binding on any subsequent owner
2010 of the hospital, psychiatric hospital or chemical dependency
2011 hospital, if the ownership of the facility is transferred at any
2012 time after the issuance of the certificate of need. Agreement
2013 that the hospital, psychiatric hospital or chemical dependency
2014 hospital will not participate in the Medicaid program shall be a
2015 condition of the issuance of a certificate of need to any person
2016 under this subparagraph (i), and if such hospital, psychiatric
2017 hospital or chemical dependency hospital at any time after the
2018 issuance of the certificate of need, regardless of the ownership
2019 of the facility, participates in the Medicaid program or admits or
2020 keeps any patients in the hospital, psychiatric hospital or
2021 chemical dependency hospital who are participating in the Medicaid
2022 program, the State Department of Health shall revoke the
2023 certificate of need, if it is still outstanding, and shall deny or
2024 revoke the license of the hospital, psychiatric hospital or
2025 chemical dependency hospital, at the time that the department
2026 determines, after a hearing complying with due process, that the
2027 hospital, psychiatric hospital or chemical dependency hospital has



2028 failed to comply with any of the conditions upon which the
2029 certificate of need was issued, as provided in this subparagraph
2030 (i) and in the written agreement by the recipient of the
2031 certificate of need.

2032 (ii) The department may issue a certificate of
2033 need for the conversion of existing beds in a county hospital in
2034 Choctaw County from acute care beds to child/adolescent chemical
2035 dependency beds. For purposes of this subparagraph (ii), the
2036 provisions of Section 41-7-193(1) requiring substantial compliance
2037 with the projection of need as reported in the current State
2038 Health Plan are waived. The total number of beds that may be
2039 authorized under authority of this subparagraph shall not exceed
2040 twenty (20) beds. There shall be no prohibition or restrictions
2041 on participation in the Medicaid program (Section 43-13-101 et
2042 seq.) for the hospital receiving the certificate of need
2043 authorized under this subparagraph or for the beds converted
2044 pursuant to the authority of that certificate of need.

2045 (iii) The department may issue a certificate or
2046 certificates of need for the construction or expansion of
2047 child/adolescent psychiatric beds or the conversion of other beds
2048 to child/adolescent psychiatric beds in Warren County. For
2049 purposes of this subparagraph (iii), the provisions of Section
2050 41-7-193(1) requiring substantial compliance with the projection
2051 of need as reported in the current State Health Plan are waived.
2052 The total number of beds that may be authorized under the
2053 authority of this subparagraph shall not exceed twenty (20) beds.
2054 There shall be no prohibition or restrictions on participation in
2055 the Medicaid program (Section 43-13-101 et seq.) for the person
2056 receiving the certificate of need authorized under this
2057 subparagraph or for the beds converted pursuant to the authority
2058 of that certificate of need.

2059 If by January 1, 2002, there has been no significant
2060 commencement of construction of the beds authorized under this



2061 subparagraph (iii), or no significant action taken to convert
2062 existing beds to the beds authorized under this subparagraph, then
2063 the certificate of need that was previously issued under this
2064 subparagraph shall expire. If the previously issued certificate
2065 of need expires, the department may accept applications for
2066 issuance of another certificate of need for the beds authorized
2067 under this subparagraph, and may issue a certificate of need to
2068 authorize the construction, expansion or conversion of the beds
2069 authorized under this subparagraph.

2070 (iv) The department shall issue a certificate of
2071 need to the Region 7 Mental Health/Retardation Commission for the
2072 construction or expansion of child/adolescent psychiatric beds or
2073 the conversion of other beds to child/adolescent psychiatric beds
2074 in any of the counties served by the commission. For purposes of
2075 this subparagraph (iv), the provisions of Section 41-7-193(1)
2076 requiring substantial compliance with the projection of need as
2077 reported in the current State Health Plan are waived. The total
2078 number of beds that may be authorized under the authority of this
2079 subparagraph shall not exceed twenty (20) beds. There shall be no
2080 prohibition or restrictions on participation in the Medicaid
2081 program (Section 43-13-101 et seq.) for the person receiving the
2082 certificate of need authorized under this subparagraph or for the
2083 beds converted pursuant to the authority of that certificate of
2084 need.

2085 (v) The department may issue a certificate of need
2086 to any county hospital located in Leflore County for the
2087 construction or expansion of adult psychiatric beds or the
2088 conversion of other beds to adult psychiatric beds, not to exceed
2089 twenty (20) beds, provided that the recipient of the certificate
2090 of need agrees in writing that the adult psychiatric beds will not
2091 at any time be certified for participation in the Medicaid program
2092 and that the hospital will not admit or keep any patients who are
2093 participating in the Medicaid program in any of such adult



2094 psychiatric beds. This written agreement by the recipient of the
2095 certificate of need shall be fully binding on any subsequent owner
2096 of the hospital if the ownership of the hospital is transferred at
2097 any time after the issuance of the certificate of need. Agreement
2098 that the adult psychiatric beds will not be certified for
2099 participation in the Medicaid program shall be a condition of the
2100 issuance of a certificate of need to any person under this
2101 subparagraph (v), and if such hospital at any time after the
2102 issuance of the certificate of need, regardless of the ownership
2103 of the hospital, has any of such adult psychiatric beds certified
2104 for participation in the Medicaid program or admits or keeps any
2105 Medicaid patients in such adult psychiatric beds, the State
2106 Department of Health shall revoke the certificate of need, if it
2107 is still outstanding, and shall deny or revoke the license of the
2108 hospital at the time that the department determines, after a
2109 hearing complying with due process, that the hospital has failed
2110 to comply with any of the conditions upon which the certificate of
2111 need was issued, as provided in this subparagraph and in the
2112 written agreement by the recipient of the certificate of need.

2113 (vi) The department may issue a certificate or
2114 certificates of need for the expansion of child psychiatric beds
2115 or the conversion of other beds to child psychiatric beds at the
2116 University of Mississippi Medical Center. For purposes of this
2117 subparagraph (vi), the provisions of Section 41-7-193(1) requiring
2118 substantial compliance with the projection of need as reported in
2119 the current State Health Plan are waived. The total number of
2120 beds that may be authorized under the authority of this
2121 subparagraph shall not exceed fifteen (15) beds. There shall be
2122 no prohibition or restrictions on participation in the Medicaid
2123 program (Section 43-13-101 et seq.) for the hospital receiving the
2124 certificate of need authorized under this subparagraph or for the
2125 beds converted pursuant to the authority of that certificate of
2126 need.



2127 (b) From and after July 1, 1990, no hospital,
2128 psychiatric hospital or chemical dependency hospital shall be
2129 authorized to add any child/adolescent psychiatric or
2130 child/adolescent chemical dependency beds or convert any beds of
2131 another category to child/adolescent psychiatric or
2132 child/adolescent chemical dependency beds without a certificate of
2133 need under the authority of subsection (1)(c) of this section.

2134 (5) The department may issue a certificate of need to a
2135 county hospital in Winston County for the conversion of fifteen
2136 (15) acute care beds to geriatric psychiatric care beds.

2137 (6) The State Department of Health shall issue a certificate
2138 of need to a Mississippi corporation qualified to manage a
2139 long-term care hospital as defined in Section 41-7-173(h)(xii) in
2140 Harrison County, not to exceed eighty (80) beds, including any
2141 necessary renovation or construction required for licensure and
2142 certification, provided that the recipient of the certificate of
2143 need agrees in writing that the long-term care hospital will not
2144 at any time participate in the Medicaid program (Section 43-13-101
2145 et seq.) or admit or keep any patients in the long-term care
2146 hospital who are participating in the Medicaid program. This
2147 written agreement by the recipient of the certificate of need
2148 shall be fully binding on any subsequent owner of the long-term
2149 care hospital, if the ownership of the facility is transferred at
2150 any time after the issuance of the certificate of need. Agreement
2151 that the long-term care hospital will not participate in the
2152 Medicaid program shall be a condition of the issuance of a
2153 certificate of need to any person under this subsection (6), and
2154 if such long-term care hospital at any time after the issuance of
2155 the certificate of need, regardless of the ownership of the
2156 facility, participates in the Medicaid program or admits or keeps
2157 any patients in the facility who are participating in the Medicaid
2158 program, the State Department of Health shall revoke the
2159 certificate of need, if it is still outstanding, and shall deny or



2160 revoke the license of the long-term care hospital, at the time
2161 that the department determines, after a hearing complying with due
2162 process, that the facility has failed to comply with any of the
2163 conditions upon which the certificate of need was issued, as
2164 provided in this subsection and in the written agreement by the
2165 recipient of the certificate of need. For purposes of this
2166 subsection, the provisions of Section 41-7-193(1) requiring
2167 substantial compliance with the projection of need as reported in
2168 the current State Health Plan are hereby waived.

2169 (7) The State Department of Health may issue a certificate
2170 of need to any hospital in the state to utilize a portion of its
2171 beds for the "swing-bed" concept. Any such hospital must be in
2172 conformance with the federal regulations regarding such swing-bed
2173 concept at the time it submits its application for a certificate
2174 of need to the State Department of Health, except that such
2175 hospital may have more licensed beds or a higher average daily
2176 census (ADC) than the maximum number specified in federal
2177 regulations for participation in the swing-bed program. Any
2178 hospital meeting all federal requirements for participation in the
2179 swing-bed program which receives such certificate of need shall
2180 render services provided under the swing-bed concept to any
2181 patient eligible for Medicare (Title XVIII of the Social Security
2182 Act) who is certified by a physician to be in need of such
2183 services, and no such hospital shall permit any patient who is
2184 eligible for both Medicaid and Medicare or eligible only for
2185 Medicaid to stay in the swing beds of the hospital for more than
2186 thirty (30) days per admission unless the hospital receives prior
2187 approval for such patient from the Division of Medicaid, Office of
2188 the Governor. Any hospital having more licensed beds or a higher
2189 average daily census (ADC) than the maximum number specified in
2190 federal regulations for participation in the swing-bed program
2191 which receives such certificate of need shall develop a procedure
2192 to insure that before a patient is allowed to stay in the swing



2193 beds of the hospital, there are no vacant nursing home beds
2194 available for that patient located within a fifty-mile radius of
2195 the hospital. When any such hospital has a patient staying in the
2196 swing beds of the hospital and the hospital receives notice from a
2197 nursing home located within such radius that there is a vacant bed
2198 available for that patient, the hospital shall transfer the
2199 patient to the nursing home within a reasonable time after receipt
2200 of the notice. Any hospital which is subject to the requirements
2201 of the two (2) preceding sentences of this subsection may be
2202 suspended from participation in the swing-bed program for a
2203 reasonable period of time by the State Department of Health if the
2204 department, after a hearing complying with due process, determines
2205 that the hospital has failed to comply with any of those
2206 requirements.

2207 (8) The Department of Health shall not grant approval for or
2208 issue a certificate of need to any person proposing the new
2209 construction of, addition to or expansion of a health care
2210 facility as defined in subparagraph (viii) of Section 41-7-173(h),
2211 except as hereinafter provided: The department may issue a
2212 certificate of need to a nonprofit corporation located in Madison
2213 County, Mississippi, for the construction, expansion or conversion
2214 of not more than twenty (20) beds in a community living program
2215 for developmentally disabled adults in a facility as defined in
2216 subparagraph (viii) of Section 41-7-173(h). For purposes of this
2217 subsection (8), the provisions of Section 41-7-193(1) requiring
2218 substantial compliance with the projection of need as reported in
2219 the current State Health Plan and the provisions of Section
2220 41-7-197 requiring a formal certificate of need hearing process
2221 are waived. There shall be no prohibition or restrictions on
2222 participation in the Medicaid program for the person receiving the
2223 certificate of need authorized under this subsection (8).

2224 (9) The Department of Health shall not grant approval for or
2225 issue a certificate of need to any person proposing the



2226 establishment of, or expansion of the currently approved territory
2227 of, or the contracting to establish a home office, subunit or
2228 branch office within the space operated as a health care facility
2229 as defined in Section 41-7-173(h) (i) through (viii) by a health
2230 care facility as defined in subparagraph (ix) of Section
2231 41-7-173(h).

2232 (10) Health care facilities owned and/or operated by the
2233 state or its agencies are exempt from the restraints in this
2234 section against issuance of a certificate of need if such addition
2235 or expansion consists of repairing or renovation necessary to
2236 comply with the state licensure law. This exception shall not
2237 apply to the new construction of any building by such state
2238 facility. This exception shall not apply to any health care
2239 facilities owned and/or operated by counties, municipalities,
2240 districts, unincorporated areas, other defined persons, or any
2241 combination thereof.

2242 (11) The new construction, renovation or expansion of or
2243 addition to any health care facility defined in subparagraph (ii)
2244 (psychiatric hospital), subparagraph (iv) (skilled nursing
2245 facility), subparagraph (vi) (intermediate care facility),
2246 subparagraph (viii) (intermediate care facility for the mentally
2247 retarded) and subparagraph (x) (psychiatric residential treatment
2248 facility) of Section 41-7-173(h) which is owned by the State of
2249 Mississippi and under the direction and control of the State
2250 Department of Mental Health, and the addition of new beds or the
2251 conversion of beds from one category to another in any such
2252 defined health care facility which is owned by the State of
2253 Mississippi and under the direction and control of the State
2254 Department of Mental Health, shall not require the issuance of a
2255 certificate of need under Section 41-7-171 et seq.,
2256 notwithstanding any provision in Section 41-7-171 et seq. to the
2257 contrary.



2258 (12) The new construction, renovation or expansion of or
2259 addition to any veterans homes or domiciliaries for eligible
2260 veterans of the State of Mississippi as authorized under Section
2261 35-1-19 shall not require the issuance of a certificate of need,
2262 notwithstanding any provision in Section 41-7-171 et seq. to the
2263 contrary.

2264 (13) [Repealed]

2265 (14) The State Department of Health shall issue a
2266 certificate of need to any hospital which is currently licensed
2267 for two hundred fifty (250) or more acute care beds and is located
2268 in any general hospital service area not having a comprehensive
2269 cancer center, for the establishment and equipping of such a
2270 center which provides facilities and services for outpatient
2271 radiation oncology therapy, outpatient medical oncology therapy,
2272 and appropriate support services including the provision of
2273 radiation therapy services. The provisions of Section 41-7-193(1)
2274 regarding substantial compliance with the projection of need as
2275 reported in the current State Health Plan are waived for the
2276 purpose of this subsection.

2277 (15) The State Department of Health may authorize the
2278 transfer of hospital beds, not to exceed sixty (60) beds, from the
2279 North Panola Community Hospital to the South Panola Community
2280 Hospital. The authorization for the transfer of those beds shall
2281 be exempt from the certificate of need review process.

2282 (16) The State Department of Health shall issue any
2283 certificates of need necessary for Mississippi State University
2284 and a public or private health care provider to jointly acquire
2285 and operate a linear accelerator and a magnetic resonance imaging
2286 unit. Those certificates of need shall cover all capital
2287 expenditures related to the project between Mississippi State
2288 University and the health care provider, including, but not
2289 limited to, the acquisition of the linear accelerator, the
2290 magnetic resonance imaging unit and other radiological modalities;



2291 the offering of linear accelerator and magnetic resonance imaging
2292 services; and the cost of construction of facilities in which to
2293 locate these services. The linear accelerator and the magnetic
2294 resonance imaging unit shall be (a) located in the City of
2295 Starkville, Oktibbeha County, Mississippi; (b) operated jointly by
2296 Mississippi State University and the public or private health care
2297 provider selected by Mississippi State University through a
2298 request for proposals (RFP) process in which Mississippi State
2299 University selects, and the Board of Trustees of State
2300 Institutions of Higher Learning approves, the health care provider
2301 that makes the best overall proposal; (c) available to Mississippi
2302 State University for research purposes two-thirds (2/3) of the
2303 time that the linear accelerator and magnetic resonance imaging
2304 unit are operational; and (d) available to the public or private
2305 health care provider selected by Mississippi State University and
2306 approved by the Board of Trustees of State Institutions of Higher
2307 Learning one-third (1/3) of the time for clinical, diagnostic and
2308 treatment purposes. For purposes of this subsection, the
2309 provisions of Section 41-7-193(1) requiring substantial compliance
2310 with the projection of need as reported in the current State
2311 Health Plan are waived.

2312 (17) The State Department of Health shall issue a
2313 certificate of need for the construction of an acute care hospital
2314 in Kemper County, not to exceed twenty-five (25) beds, which shall
2315 be named the "John C. Stennis Memorial Hospital." In issuing the
2316 certificate of need under this subsection, the department shall
2317 give priority to a hospital located in Lauderdale County that has
2318 two hundred fifteen (215) beds. For purposes of this subsection,
2319 the provisions of Section 41-7-193(1) requiring substantial
2320 compliance with the projection of need as reported in the current
2321 State Health Plan and the provisions of Section 41-7-197 requiring
2322 a formal certificate of need hearing process are waived. There
2323 shall be no prohibition or restrictions on participation in the



2324 Medicaid program (Section 43-13-101 et seq.) for the person or
2325 entity receiving the certificate of need authorized under this
2326 subsection or for the beds constructed under the authority of that
2327 certificate of need.

2328 (18) Nothing in this section or in any other provision of
2329 Section 41-7-171 et seq. shall prevent any nursing facility from
2330 designating an appropriate number of existing beds in the facility
2331 as beds for providing care exclusively to patients with
2332 Alzheimer's disease.

2333 **SECTION 15.** This act shall take effect and be in force from
2334 and after its passage.

