MISSISSIPPI LEGISLATURE REGULAR SESSION 2023

By: Representative Zuber To: Insurance

HOUSE BILL NO. 1134

AN ACT TO BRING FORWARD SECTIONS 25-15-3, 25-15-5, 25-15-7, 25-15-9, 25-15-11, 25-15-13, 25-15-14, 25-15-15, 25-15-16, 25-15-17, 25-15-19, 25-15-23, 25-15-303, 37-151-95, 41-7-173, 41-7-175, 41-7-183, 41-7-185, 41-7-191, 41-7-193, 83-9-22 AND 83-9-24, MISSISSIPPI CODE OF 1972, WHICH ESTABLISH AND REFERENCE THE STATE AND SCHOOL EMPLOYEES LIFE AND HEALTH INSURANCE PLAN, FOR THE PURPOSE OF POSSIBLE AMENDMENT; AND FOR RELATED PURPOSES.

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

SECTION 1. Section 25-15-3, Mississippi Code of 1972, is brought forward as follows:

25-15-3. For the purposes of this article, the words and phrases used herein shall have the following meanings:

(a) "Employee" means a person who works full time for the State of Mississippi and receives his compensation in a direct payment from a department, agency or institution of the state government and any person who works full time for any school district, community/junior college, public library or university-based program authorized under Section 37-23-31 for deaf, aphasic and emotionally disturbed children or any regular nonstudent bus driver. This shall include legislators, employees

of the legislative branch and the judicial branch of the state and "employees" shall include full-time salaried judges and full-time district attorneys and their staff and full-time compulsory school attendance officers. For the purposes of this article, any "employee" making contributions to the State of Mississippi retirement plan shall be considered a full-time employee.

(b) "Department" means the Department of Finance and Administration.

(c) "Plan" means the State and School Employees Life and Health Insurance Plan created under this article.

(d) "Fund" means the State and School Employees Insurance Fund set up under this article.

(e) "Retiree" means any employee retired under the Mississippi retirement plan.

(f) "Board" means the State and School Employees Health Insurance Management Board created under Section 25-15-303.

SECTION 2. Section 25-15-5, Mississippi Code of 1972, is brought forward as follows:

25-15-5. (1) The board shall administer the plan and is authorized to adopt and promulgate rules and regulations for its administration, subject to the terms and limitations contained in this article.

(2) The board shall develop a five-year strategic plan for the insurance plan established by Section 25-15-3 et seq. The strategic plan shall address, but not be limited to:

(a) Changing trends in the health care industry, and how they effect delivery of services to members of the plan.

(b) Alternative service delivery systems.

(c) Any foreseeable problems with the present system of delivering and administering health care benefits in Mississippi.

(d) The development of options and recommendations for changes in the plan.

(3) To carry out the requirements of subsection (2) of this section, the board may conduct formal research, including questionnaires and attitudinal surveys of members' needs and preferences with respect to service delivery.

(4) After the board has complied with all provisions of Section 25-15-9 regarding the establishment of the plan, it shall be responsible for fully disclosing to plan members the provisions of the plan. Such disclosure shall consist of the dissemination of educational material on the plan and any proposed changes thereto. The board shall provide members with complete educational materials at least thirty (30) days before the date upon which the plan's members must select a plan option for health care services. The board shall further use the resources of the Mississippi Authority for Educational Television or other state agency, university or college to provide information on proposed changes. The board may also use other state-owned media, as well as public service announcements on private media to disseminate information regarding proposed changes in the plan.

(5) The board shall develop and make available for public review at its offices a comprehensive plan document which documents all benefits for which members of the plan created by Section 25-15-3 et seq. are eligible. This document shall be typed and maintained also at the offices of any administrator contracted with in accordance with Section 25-15-301.

(6) (a) The board may enter into contracts with accountants, actuaries and other persons from the private sector whose skills are necessary to carry out the purposes of Section 25-15-3 et seq.

(b) Before the board enters into any contract for services as provided in paragraph (a) of this subsection, the board shall first determine that the services are required, and that the staff of the board and personnel of other state agencies are not sufficiently experienced to provide the services.

(c) If the service is to be rendered for a period of in excess of six (6) months, the board shall seek and obtain bids for the service in a manner identical to that provided for in Section 25-15-301, subsection (1)(a) and (b) except for those provisions which specifically state criteria which are applicable only to third-party administrators contracted with in accordance with Section 25-15-3 et seq.

(d) The board is also authorized to procure legal services if it deems these services to be necessary to carry out its responsibilities under Section 25-15-3 et seq.

SECTION 3. Section 25-15-7, Mississippi Code of 1972, is brought forward as follows:

25-15-7. Such health insurance shall not include expense incurred by or on account of an individual prior to July 1, 1972, as to him; dental care and treatment, except dental surgery and appliances to the extent necessary for the correction of damage caused by accidental injury while covered by the plan, or as a direct result of disease covered by the plan; eyeglasses, hearing aids for individuals over the age of twenty-one (21) years, and examinations for the prescription or fitting thereof; cosmetic surgery or treatment, except to the extent necessary for correction of damage by accidental injury while covered by the plan or as a direct result of disease covered by the plan; services received in a hospital owned or operated by the United States government for which no charge is made; services received for injury or sickness due to war or any act of war, whether declared or undeclared, which war or act of war shall have occurred after July 1, 1972; expense for which the individual is not required to make payment; expenses to the extent of benefits provided under any employer group plan other than this plan, in which the state participates in the cost thereof; and such other expenses as may be excluded by regulations of the board.

SECTION 4. Section 25-15-9, Mississippi Code of 1972, is brought forward as follows:

25-15-9. (1) (a) The board shall design a plan of health insurance for state employees that provides benefits for semiprivate rooms in addition to other incidental coverages that the board deems necessary. The amount of the coverages shall be in such reasonable amount as may be determined by the board to be adequate, after due consideration of current health costs in Mississippi. The plan shall also include major medical benefits in such amounts as the board determines. The plan shall provide for coverage for telemedicine services as provided in Section 83-9-351. The board is also authorized to accept bids for such alternate coverage and optional benefits as the board deems proper. The board is authorized to accept bids for surgical services that include assistance in locating a surgeon, setting up initial consultation, travel, a negotiated single case rate bundle and payment for orthopedic, spine, bariatric, cardiovascular and general surgeries. The surgical services may only utilize surgeons and facilities located in the State of Mississippi unless otherwise provided by the board. Any contract for alternative coverage and optional benefits shall be awarded by the board after it has carefully studied and evaluated the bids and selected the best and most cost-effective bid. The board may reject all of the bids; however, the board shall notify all bidders of the rejection and shall actively solicit new bids if all bids are rejected. The board may employ or contract for such consulting or actuarial services as may be necessary to formulate the plan, and to assist

the board in the preparation of specifications and in the process of advertising for the bids for the plan. Those contracts shall be solicited and entered into in accordance with Section 25-15-5. The board shall keep a record of all persons, agents and corporations who contract with or assist the board in preparing and developing the plan. The board in a timely manner shall provide copies of this record to the members of the advisory council created in this section and those legislators, or their designees, who may attend meetings of the advisory council. The board shall provide copies of this record in the solicitation of bids for the administration or servicing of the self-insured program. Each person, agent or corporation that, during the previous fiscal year, has assisted in the development of the plan or employed or compensated any person who assisted in the development of the plan, and that bids on the administration or servicing of the plan, shall submit to the board a statement accompanying the bid explaining in detail its participation with the development of the plan. This statement shall include the amount of compensation paid by the bidder to any such employee during the previous fiscal year. The board shall make all such information available to the members of the advisory council and those legislators, or their designees, who may attend meetings of the advisory council before any action is taken by the board on the bids submitted. The failure of any bidder to fully and accurately comply with this paragraph shall result in the

rejection of any bid submitted by that bidder or the cancellation of any contract executed when the failure is discovered after the acceptance of that bid. The board is authorized to promulgate rules and regulations to implement the provisions of this subsection.

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

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

(b) There is created an advisory council to advise the board in the formulation of the State and School Employees Health Insurance Plan. The council shall be composed of the State Insurance Commissioner, or his designee, an

employee-representative of the institutions of higher learning appointed by the board of trustees thereof, an employee-representative of the Department of Transportation appointed by the director thereof, an employee-representative of the Department of Revenue appointed by the Commissioner of Revenue, an employee-representative of the Mississippi Department of Health appointed by the State Health Officer, an employee-representative of the Mississippi Department of Corrections appointed by the Commissioner of Corrections, and an employee-representative of the Department of Human Services appointed by the Executive Director of Human Services, two (2) certificated public school administrators appointed by the State Board of Education, two (2) certificated classroom teachers appointed by the State Board of Education, a noncertificated school employee appointed by the State Board of Education and a community/junior college employee appointed by the Mississippi Community College Board.

The Lieutenant Governor may designate the Secretary of the Senate, the Chairman of the Senate Appropriations Committee, the Chairman of the Senate Education Committee and the Chairman of the Senate Insurance Committee, and the Speaker of the House of Representatives may designate the Clerk of the House, the Chairman of the House Appropriations Committee, the Chairman of the House Education Committee and the Chairman of the House Insurance Committee, to attend any meeting of the State and School Employees

Insurance Advisory Council. The appointing authorities may designate an alternate member from their respective houses to serve when the regular designee is unable to attend the meetings of the council. Those designees shall have no jurisdiction or vote on any matter within the jurisdiction of the council. For attending meetings of the council, the legislators shall receive per diem and expenses, which shall be paid from the contingent expense funds of their respective houses in the same amounts as provided for committee meetings when the Legislature is not in session; however, no per diem and expenses for attending meetings of the council will be paid while the Legislature is in session. No per diem and expenses will be paid except for attending meetings of the council without prior approval of the proper committee in their respective houses.

(c) No change in the terms of the State and School Employees Health Insurance Plan may be made effective unless the board, or its designee, has provided notice to the State and School Employees Health Insurance Advisory Council and has called a meeting of the council at least fifteen (15) days before the effective date of the change. If the State and School Employees Health Insurance Advisory Council does not meet to advise the board on the proposed changes, the changes to the plan shall become effective at such time as the board has informed the council that the changes shall become effective.

(d) **Medical benefits for retired employees and dependents under age sixty-five (65) years and not eligible for Medicare benefits.** For employees who retire before July 1, 2005, and for employees retiring due to work-related disability under the Public Employees' Retirement System, the same health insurance coverage as for all other active employees and their dependents shall be available to retired employees and all dependents under age sixty-five (65) years who are not eligible for Medicare benefits, the level of benefits to be the same level as for all other active participants. For employees who retire on or after July 1, 2005, and not retiring due to work-related disability under the Public Employees' Retirement System, the same health insurance coverage as for all other active employees and their dependents shall be available to those retiring employees and all dependents under age sixty-five (65) years who are not eligible for Medicare benefits only if the retiring employees were participants in the State and School Employees Health Insurance Plan for four (4) years or more before their retirement, the level of benefits to be the same level as for all other active participants. This section will apply to those employees who retire due to one hundred percent (100%) medical disability as well as those employees electing early retirement.

(e) **Medical benefits for retired employees and dependents over age sixty-five (65) years or otherwise eligible for Medicare benefits.** For employees who retire before July 1,

2005, and for employees retiring due to work-related disability under the Public Employees' Retirement System, the health insurance coverage available to retired employees over age sixty-five (65) years or otherwise eligible for Medicare benefits, and all dependents over age sixty-five (65) years or otherwise eligible for Medicare benefits, shall be the major medical coverage. For employees retiring on or after July 1, 2005, and not retiring due to work-related disability under the Public Employees' Retirement System, the health insurance coverage described in this paragraph (e) shall be available to those retiring employees only if they were participants in the State and School Employees Health Insurance Plan for four (4) years or more and are over age sixty-five (65) years or otherwise eligible for Medicare benefits, and to all dependents over age sixty-five (65) years or otherwise eligible for Medicare benefits. Benefits shall be reduced by Medicare benefits as though the Medicare benefits were the base plan.

All covered individuals shall be assumed to have full Medicare coverage, Parts A and B; and any Medicare payments under both Parts A and B shall be computed to reduce benefits payable under this plan.

(f) Lifetime maximum: The lifetime maximum amount of benefits payable under the health insurance plan for each participant is Two Million Dollars ($2,000,000.00).

(2) Nonduplication of benefits — reduction of benefits by Title XIX benefits: When benefits would be payable under more than one (1) group plan, benefits under those plans will be coordinated to the extent that the total benefits under all plans will not exceed the total expenses incurred.

Benefits for hospital or surgical or medical benefits shall be reduced by any similar benefits payable in accordance with Title XIX of the Social Security Act or under any amendments thereto, or any implementing legislation.

Benefits for hospital or surgical or medical benefits shall be reduced by any similar benefits payable by workers' compensation.

No health care benefits under the state plan shall restrict coverage for medically appropriate treatment prescribed by a physician and agreed to by a fully informed insured, or if the insured lacks legal capacity to consent by a person who has legal authority to consent on his or her behalf, based on an insured's diagnosis with a terminal condition. As used in this paragraph, "terminal condition" means any aggressive malignancy, chronic end-stage cardiovascular or cerebral vascular disease, or any other disease, illness or condition which physician diagnoses as terminal.

Not later than January 1, 2016, the state health plan shall not require a higher co-payment, deductible or coinsurance amount for patient-administered anti-cancer medications, including, but

not limited to, those orally administered or self-injected, than it requires for anti-cancer medications that are injected or intravenously administered by a health care provider, regardless of the formulation or benefit category determination by the plan. For the purposes of this paragraph, the term "anti-cancer medications" has the meaning as defined in Section 83-9-24.

(3) (a) Schedule of life insurance benefits — group term: The amount of term life insurance for each active employee of a department, agency or institution of the state government shall not be in excess of One Hundred Thousand Dollars ($100,000.00), or twice the amount of the employee's annual wage to the next highest One Thousand Dollars ($1,000.00), whichever may be less, but in no case less than Thirty Thousand Dollars ($30,000.00), with a like amount for accidental death and dismemberment on a twenty-four-hour basis. The plan will further contain a premium waiver provision if a covered employee becomes totally and permanently disabled before age sixty-five (65) years. Employees retiring after June 30, 1999, shall be eligible to continue life insurance coverage in an amount of Five Thousand Dollars ($5,000.00), Ten Thousand Dollars ($10,000.00) or Twenty Thousand Dollars ($20,000.00) into retirement.

(b) Effective October 1, 1999, schedule of life insurance benefits — group term: The amount of term life insurance for each active employee of any school district, community/junior college, public library or university-based

program authorized under Section 37-23-31 for deaf, aphasic and emotionally disturbed children or any regular nonstudent bus driver shall not be in excess of One Hundred Thousand Dollars ($100,000.00), or twice the amount of the employee's annual wage to the next highest One Thousand Dollars ($1,000.00), whichever may be less, but in no case less than Thirty Thousand Dollars ($30,000.00), with a like amount for accidental death and dismemberment on a twenty-four-hour basis. The plan will further contain a premium waiver provision if a covered employee of any school district, community/junior college, public library or university-based program authorized under Section 37-23-31 for deaf, aphasic and emotionally disturbed children or any regular nonstudent bus driver becomes totally and permanently disabled before age sixty-five (65) years. Employees of any school district, community/junior college, public library or university-based program authorized under Section 37-23-31 for deaf, aphasic and emotionally disturbed children or any regular nonstudent bus driver retiring after September 30, 1999, shall be eligible to continue life insurance coverage in an amount of Five Thousand Dollars ($5,000.00), Ten Thousand Dollars ($10,000.00) or Twenty Thousand Dollars ($20,000.00) into retirement.

(4) Any eligible employee who on March 1, 1971, was participating in a group life insurance program that has provisions different from those included in this article and for which the State of Mississippi was paying a part of the premium

may, at his discretion, continue to participate in that plan. The employee shall pay in full all additional costs, if any, above the minimum program established by this article. Under no circumstances shall any individual who begins employment with the state after March 1, 1971, be eligible for the provisions of this subsection.

(5) The board may offer medical savings accounts as defined in Section 71-9-3 as a plan option.

(6) Any premium differentials, differences in coverages, discounts determined by risk or by any other factors shall be uniformly applied to all active employees participating in the insurance plan. It is the intent of the Legislature that the state contribution to the plan be the same for each employee throughout the state.

(7) On October 1, 1999, any school district, community/junior college district or public library may elect to remain with an existing policy or policies of group life insurance with an insurance company approved by the State and School Employees Health Insurance Management Board, in lieu of participation in the State and School Life Insurance Plan. On or after July 1, 2004, until October 1, 2004, any school district, community/junior college district or public library may elect to choose a policy or policies of group life insurance existing on October 1, 1999, with an insurance company approved by the State and School Employees Health Insurance Management Board in lieu of

participation in the State and School Life Insurance Plan. The state's contribution of up to fifty percent (50%) of the active employee's premium under the State and School Life Insurance Plan may be applied toward the cost of coverage for full-time employees participating in the approved life insurance company group plan. For purposes of this subsection (7), "life insurance company group plan" means a plan administered or sold by a private insurance company. After October 1, 1999, the board may assess charges in addition to the existing State and School Life Insurance Plan rates to such employees as a condition of enrollment in the State and School Life Insurance Plan. In order for any life insurance company group plan to be approved by the State and School Employees Health Insurance Management Board under this subsection (7), it shall meet the following criteria:

(a) The insurance company offering the group life insurance plan shall be rated "A-" or better by A.M. Best state insurance rating service and be licensed as an admitted carrier in the State of Mississippi by the Mississippi Department of Insurance.

(b) The insurance company group life insurance plan shall provide the same life insurance, accidental death and dismemberment insurance and waiver of premium benefits as provided in the State and School Life Insurance Plan.

(c) The insurance company group life insurance plan shall be fully insured, and no form of self-funding life insurance by the company shall be approved.

(d) The insurance company group life insurance plan shall have one (1) composite rate per One Thousand Dollars ($1,000.00) of coverage for active employees regardless of age and one (1) composite rate per One Thousand Dollars ($1,000.00) of coverage for all retirees regardless of age or type of retiree.

(e) The insurance company and its group life insurance plan shall comply with any administrative requirements of the State and School Employees Health Insurance Management Board. If any insurance company providing group life insurance benefits to employees under this subsection (7) fails to comply with any requirements specified in this subsection or any administrative requirements of the board, the state shall discontinue providing funding for the cost of that insurance.

SECTION 5. Section 25-15-11, Mississippi Code of 1972, is brought forward as follows:

25-15-11. (1) The board is authorized to execute a contract or contracts to provide the benefits under the plan. Such contract or contracts may be executed with one or more corporations or associations licensed to transact life and accident and health insurance business in this state; however, no such contract shall be executed with any corporation, association or company domiciled in any other state except that such

corporation, association or company shall meet the conditions and terms for a like contract established by the state of the domicile of such corporation, association or company for a Mississippi corporation, association or company. No corporation, association or company with less than five (5) years' experience in the life and health field may bid. All of the benefits to be provided under the plan may be included in one or more similar contracts, or the benefits may be classified into different types with each type included under one or more similar contracts issued by the same or different companies.

The board shall supply the statistical information upon which a quotation is to be calculated, upon request, to all carriers licensed in the state. Bids may be accepted at the discretion of the board, and the board shall have the right to adjust rates on an annual basis if the board shall deem such adjustment necessary. The plan for active employees shall be on retention accounting basis, and a separate retention accounting basis shall be used for retired employees. Any additional written information the carrier wishes to submit, supporting the proposed benefits and premium rate, may accompany the proposal. After receiving the proposals, the board shall determine whether to contract with the carrier which has been determined to have submitted the lowest and best bid, or to reject all such bids and receive new proposals.

The board shall authorize any corporation licensed to transact accident and health insurance business in this state

issuing any such contract to reinsure portions of such contract with any other such corporation which elected to be a reinsurer and is legally competent to enter into a reinsurance agreement. The board may designate one or more of such corporations as the administering corporation or corporations. Each employee who is covered under any such contract or contracts shall receive a certificate setting forth the benefits to which the employee is entitled thereunder, to whom such benefits shall be payable, to whom claims should be submitted, and summarizing the provisions of the contract principally affecting the employee. Such certificate shall be in lieu of the certificate which the corporation or corporations issuing such contract or contracts would otherwise issue.

The board may, as of the end of any contract year, discontinue any contract or contracts it has executed with any corporation or corporations and replace it or them with a contract or contracts in any other corporation or corporations meeting the requirements of this section.

The board may reject any and all bids and contracts under this section and may elect for the state to become a self-insurer; however, administration and service of any such self-insured program may be contracted to a third party by the board.

Any contract with a third party to administer the plan shall be bid and entered into in accordance with the procedures provided in Section 25-15-301.

(2) By September 30 of each year, the board shall report to the Joint Legislative Budget Committee, Senate Insurance Committee, House Insurance Committee, Senate Education Committee, House Education Committee and Joint Legislative Committee on Performance Evaluation and Expenditure Review the condition of the State and School Employees Life and Health Insurance Plan. Such report shall contain for the most recently completed fiscal year, but not be limited to, the following:

(a) The plan's financial condition at the close of the fiscal year.

(b) The history of yearly claims paid and premiums received for each premium class, including, but not limited to, active employees, dependents and retirees.

(c) The history of loss ratios for the active employees, dependents and retirees premium classes as well as historical trend of such ratios. For the purposes of this section, the term "loss ratios" means claims paid by the plan for each premium class divided by premiums received by the plan for insurance coverage of the members in that premium class.

(d) Budgetary information, including:

(i) A detailed breakdown of all expenditures of the plan, administrative and otherwise, for the most recently completed fiscal year and projected expenditures, administrative and otherwise, for the current and next fiscal year;

(ii) A schedule of all contracts, administrative and otherwise, executed for the benefit of the plan during the most recent completed fiscal year and those executed and anticipated for the current fiscal year; and

(iii) A description of the processes used by the board to procure all contracts, administrative and otherwise, as well as a description of the scope of services to be provided by each contractor.

Budgetary information shall be provided in a format designated by the Joint Legislative Budget Committee.

The Joint Legislative Budget Committee, Senate Insurance Committee, House Insurance Committee, Senate Education Committee, House Education Committee and Joint Legislative Committee on Performance Evaluation and Expenditure Review may request additional information or reports from the board on an as-needed basis.

(3) Annually, the board shall request, and the Department of Audit shall conduct, a comprehensive audit of the State and School Employees Life and Health Insurance Plan. For purposes of this section, the audit required herein shall be separate and distinct from any audit prepared in conjunction with the development of the Comprehensive Annual Financial Report (CAFR).

SECTION 6. Section 25-15-13, Mississippi Code of 1972, is brought forward as follows:

25-15-13. Each eligible employee may participate in the plan by signing up for the plan at the time of employment. Each eligible employee who declines coverage under the plan must sign a waiver of coverage. After acceptance in the plan, the employee may cease his or her participation by filing a specific disclaimer with the board. Forms for this purpose shall be prescribed and issued by the board. All eligible employees will be eligible to participate in the plan on the effective date of the plan or on the date on which they are employed by the state, whichever is later, provided they make the necessary contributions as provided in this article. Spouses of employees, unmarried dependent children from birth to age nineteen (19) years, unmarried dependent children who are full-time students up to age twenty-five (25) years, and physically or mentally handicapped children, regardless of age, are eligible under the plan as of the date the employee becomes eligible. If both spouses are eligible employees who participate in the plan, the benefits shall apply individually to each spouse by virtue of his or her participation in the plan. If those spouses also have one or more eligible dependents participating in the plan, the cost of their dependents shall be calculated at a special family plan rate. The cost for participation by the dependents shall be paid by the spouse who elects to carry such dependents under his or her coverage.

SECTION 7. Section 25-15-14, Mississippi Code of 1972, is brought forward as follows:

25-15-14. Any elected state or district official who does not run for reelection or who is defeated before being entitled to receive a retirement allowance shall be eligible to continue to participate in the State and School Employees Health Insurance Plan under the same conditions and coverages for retired employees.

SECTION 8. Section 25-15-15, Mississippi Code of 1972, is brought forward as follows:

25-15-15. (1) The board is authorized to determine the manner in which premiums and contributions by the state agencies, local school districts, colleges, universities, community/junior colleges and public libraries shall be collected to provide the self-insured health insurance program for employees as provided under this article. The state shall provide fifty percent (50%) of the cost of the above life insurance plan for all active full-time employees. The state shall provide one hundred percent (100%) of the cost of the health insurance plan for active full-time employees initially employed before January 1, 2006, except as otherwise provided in this section. For active full-time employees initially employed on or after January 1, 2006, the state shall provide one hundred percent (100%) of the cost of a basic level of health insurance, except as otherwise provided in this section, and the employees may pay additional amounts to purchase additional benefits or levels of coverage offered under the plan. The board, if determined to be necessary,

may assess active full-time employees a portion of the active employee premium in an amount not to exceed Twenty Dollars ($20.00) per month, notwithstanding any language in this section to the contrary. All active full-time employees shall be given the opportunity to purchase coverage for their eligible dependents with the premiums for such dependent coverage, as well as the employee's fifty percent (50%) share for his life insurance coverage, to be deductible from the employee's salary by the agency, department or institution head, which deductions, together with the fifty percent (50%) share of such life insurance premiums of such employing agency, department or institution head from funds appropriated to or authorized to be expended by the employing agency, department or institution head, shall be deposited directly into a depository bank or special fund in the State Treasury, as determined by the board. These funds and interest earned on these funds may be used for the disbursement of claims and shall be exempt from the appropriation process.

(2) The state shall provide annually, by line item in the Mississippi Library Commission appropriation bill, such funds to pay one hundred percent (100%) of the cost of health insurance under the State and School Employees Health Insurance Plan, or any lesser percentage of the cost that is not assessed to the employees by the board, for full-time library staff members in each public library in Mississippi initially employed before January 1, 2006. For full-time library staff members initially

employed on or after January 1, 2006, the state shall provide one hundred percent (100%) of the cost of a basic level of health insurance under the State and School Employees Health Insurance Plan, or any lesser percentage of the cost that is not assessed to the employees by the board, and the employees may pay additional amounts to purchase additional benefits or levels of coverage offered under the plan. The commission shall allot to each public library a sufficient amount of those funds appropriated to pay the costs of insurance for eligible employees. Any funds so appropriated by line item which are not expended during the fiscal year for which such funds were appropriated shall be carried forward for the same purposes during the next succeeding fiscal year. If any premiums for the health insurance and/or late charges and interest penalties are not paid by a public library in a timely manner, as defined by the board, the Mississippi Library Commission, upon notice by the board, shall immediately withhold all subsequent disbursements of funds to that public library.

(3) The state shall annually provide one hundred percent (100%) of the cost of the health insurance plan, or any lesser percentage of the cost that is not assessed to the employees by the board, for public school district employees who work no less than twenty (20) hours during each week and regular nonstudent school bus drivers, if such employees and school bus drivers were initially employed before January 1, 2006. For such employees and school bus drivers initially employed on or after January 1, 2006,

the state shall provide one hundred percent (100%) of the cost of a basic level of health insurance under the State and School Employees Health Insurance Plan, or any lesser percentage of the cost that is not assessed to the employees by the board, and the employees may pay additional amounts to purchase additional benefits or levels of coverage offered under the plan. Where federal funding is allowable to defray, in full or in part, the cost of participation in the program by district employees who work no less than twenty (20) hours during the week and regular nonstudent bus drivers, whose salaries are paid, in full or in part, by federal funds, the allowance under this section shall be reduced to the extent of such federal funding. Where the use of federal funds is allowable but not available, it is the intent of the Legislature that school districts contribute the cost of participation for such employees from local funds, except that parent fees for child nutrition programs shall not be increased to cover such cost.

(4) The state shall provide annually, by line item in the community/junior college appropriation bill, such funds to pay one hundred percent (100%) of the cost of the health insurance plan, or any lesser percentage of the cost that is not assessed to the employees by the board, for community/junior college district employees initially employed before January 1, 2006, who work no less than twenty (20) hours during each week. For such employees initially employed on or after January 1, 2006, the state shall

provide one hundred percent (100%) of the cost of a basic level of health insurance under the State and School Employees Health Insurance Plan, or any lesser percentage of the cost that is not assessed to the employees by the board, and the employees may pay additional amounts to purchase additional benefits or levels of coverage offered under the plan.

(5) When the use of federal funding is allowable to defray, in full or in part, the cost of participation in the insurance plan by community/junior college district employees who work no less than twenty (20) hours during each week, whose salaries are paid, in full or in part, by federal funds, the allowance under this section shall be reduced to the extent of the federal funding. Where the use of federal funds is allowable but not available, it is the intent of the Legislature that community/junior college districts contribute the cost of participation for such employees from local funds.

(6) Any community/junior college district may contribute to the cost of coverage for any district employee from local community/junior college district funds, and any public school district may contribute to the cost of coverage for any district employee from nonminimum program funds. Any part of the cost of such coverage for participating employees of public school districts and public community/junior college districts that is not paid by the state shall be paid by the participating

employees, which shall be deducted from the salaries of the employees in a manner determined by the board.

(7) Any funds appropriated for the cost of insurance by line item in the community/junior colleges appropriation bill which are not expended during the fiscal year for which such funds were appropriated shall be carried forward for the same purposes during the next succeeding fiscal year.

(8) The board may establish and enforce late charges and interest penalties or other penalties for the purpose of requiring the prompt payment of all premiums for life and health insurance permitted under this chapter. All funds in excess of the amount needed for disbursement of claims shall be deposited in a special fund in the State Treasury to be known as the State and School Employees Insurance Fund. The State Treasurer shall invest all funds in the State and School Employees Insurance Fund and all interest earned shall be credited to the State and School Employees Insurance Fund. Such funds shall be placed with one or more depositories of the state and invested on the first day such funds are available for investment in certificates of deposit, repurchase agreements or in United States Treasury bills or as otherwise authorized by law for the investment of Public Employees' Retirement System funds, as long as such investment is made from competitive offering and at the highest and best market rate obtainable consistent with any available investment alternatives; however, such investments shall not be made in

shares of stock, common or preferred, or in any other investments which would mature more than one (1) year from the date of investment. The board shall have the authority to draw from this fund periodically such funds as are necessary to operate the self-insurance plan or to pay to the insurance carrier the cost of operation of this plan, it being the purpose to limit the amount of participation by the state to fifty percent (50%) of the cost of the life insurance program and not to limit the contracting for additional benefits where the cost will be paid in full by the employee. The state shall not share in the cost of coverage for retired employees.

(9) The board shall also provide for the creation of an Insurance Reserve Fund and funds therein shall be invested by the State Treasurer with all interest earned credited to the State and School Employees Insurance Fund.

(10) Any retired employee electing to purchase retired life and health insurance will have the full cost of such insurance deducted monthly from his State of Mississippi retirement plan check or direct billed for the cost of the premium if the retirement check is insufficient to pay for the premium. If the board determines actuarially that the premium paid by the participating retirees adversely affects the overall cost of the plan to the state, then the board may impose a premium surcharge, not to exceed fifteen percent (15%), upon such participating retired employees who are under the age for Medicare eligibility

and who were initially employed before January 1, 2006. For participating retired employees who are under the age for Medicare eligibility and who were initially employed on or after January 1, 2006, the board may impose a premium surcharge in an amount the board determines actuarially to cover the full cost of insurance.

(11) This section shall stand repealed on July 1, 2026.

SECTION 9. Section 25-15-16, Mississippi Code of 1972, is brought forward as follows:

25-15-16. The public school districts of the state, in their discretion, may pay with local funds one hundred percent (100%) of the cost of the health insurance premiums of the State and School Employees Health Insurance Plan for all retired members of the Public Employees' Retirement System who are employed as school bus drivers by the school districts. No state funds shall be used for payment of the health insurance premiums under the authority of this section. If a school district chooses to pay the health insurance premiums for school bus drivers under the authority of this section, the district shall be authorized to pay any amount that is one hundred percent (100%) or less of the cost of the health insurance premiums for the school bus drivers.

SECTION 10. Section 25-15-17, Mississippi Code of 1972, is brought forward as follows:

25-15-17. (1) Any benefits payable under the plan may be made either directly to the attending physicians, hospitals, medical groups, or others furnishing the services upon which a

claim is based, or to the covered employee, upon presentation of valid bills for such services, subject to subsection (3) of this section and such provisions to facilitate payment as may be made by the board. All benefits payable under this plan shall be payable directly to the covered employee unless such covered employee shall make a valid assignment in accordance with subsection (3) of this section.

(2) The plan may not, by its terms, limit or restrict the covered employee's ability to assign the covered employee's benefits under the policy to a licensed health care provider that provides health care services to the covered employee. Any such plan provision in violation of this subsection shall be invalid.

(3) If the covered employee provides the board with written direction that all or a portion of any indemnities or benefits provided by the plan be paid to a licensed health care provider rendering hospital, nursing, medical or surgical services, then the plan shall pay directly the licensed health care provider rendering such services. That payment shall be considered payment in full to the provider, who may not bill or collect from the covered employee any amount above that payment, other than the deductible, coinsurance, copayment or other charges for equipment or services requested by the covered employee that are noncovered benefits after the signing of an explanatory document about the noncovered benefit by the covered employee.

SECTION 11. Section 25-15-19, Mississippi Code of 1972, is brought forward as follows:

25-15-19. On or before July 1, 1972, the board shall notify all department, agency and institution heads that the employee deductions shall commence on said date.

SECTION 12. Section 25-15-23, Mississippi Code of 1972, is brought forward as follows:

25-15-23. No agency, board, school district, community/junior college, public library, university, institution or authority of the state shall withdraw, or authorize any agency or institution under its management and control to withdraw, from the State and School Employees Life and Health Insurance Plan established under this chapter.

SECTION 13. Section 25-15-303, Mississippi Code of 1972, is brought forward as follows:

25-15-303. (1) There is created the State and School Employees Health Insurance Management Board, which shall administer the State and School Employees Life and Health Insurance Plan provided for under Section 25-15-3 et seq. The State and School Employees Health Insurance Management Board, hereafter referred to as the "board," shall also be responsible for administering all procedures for selecting third-party administrators provided for in Section 25-15-301.

(2) The board shall consist of the following:

(a) The Chairman of the Workers' Compensation Commission or his or her designee;

(b) The State Personnel Director, or his or her designee;

(c) The Commissioner of Insurance, or his or her designee;

(d) The Commissioner of Higher Education, or his or her designee;

(e) The State Superintendent of Public Education, or his or her designee;

(f) The Executive Director of the Department of Finance and Administration, or his or her designee;

(g) The Executive Director of the Mississippi Community College Board, or his or her designee;

(h) The Executive Director of the Public Employees' Retirement System, or his or her designee;

(i) Two (2) appointees of the Governor whose terms shall be concurrent with that of the Governor, one (1) of whom shall have experience in providing actuarial advice to companies that provide health insurance to large groups and one (1) of whom shall have experience in the day-to-day management and administration of a large self-funded health insurance group;

(j) The Chairman of the Senate Insurance Committee, or his or her designee;

(k) The Chairman of the House of Representatives Insurance Committee, or his or her designee;

(l) The Chairman of the Senate Appropriations Committee, or his or her designee; and

(m) The Chairman of the House of Representatives Appropriations Committee, or his or her designee.

The legislators, or their designees, shall serve as ex officio, nonvoting members of the board.

The Executive Director of the Department of Finance and Administration shall be the chairman of the board.

(3) The board shall meet at least monthly and maintain minutes of the meetings. A quorum shall consist of a majority of the authorized voting membership of the board. The board shall have the sole authority to promulgate rules and regulations governing the operations of the insurance plans and shall be vested with all legal authority necessary and proper to perform this function including, but not limited to:

(a) Defining the scope and coverages provided by the insurance plan;

(b) Seeking proposals for services or insurance through competitive processes where required by law and selecting service providers or insurers under procedures provided for by law; and

(c) Developing and adopting strategic plans and budgets for the insurance plan.

The department shall employ a State Insurance Administrator, who shall be responsible for the day-to-day management and administration of the insurance plan. The Department of Finance and Administration shall provide to the board on a full-time basis personnel and technical support necessary and sufficient to effectively and efficiently carry out the requirements of this section.

(4) Members of the board shall not receive any compensation or per diem, but may receive travel reimbursement provided for under Section 25-3-41 except that the legislators shall receive per diem and expenses, which shall be paid from the contingent expense funds of their respective houses in the same amounts as provided for committee meetings when the Legislature is not in session; however, no per diem and expenses for attending meetings of the board shall be paid while the Legislature is in session.

SECTION 14. Section 37-151-95, Mississippi Code of 1972, is brought forward as follows:

37-151-95. Adequate education program funds shall include one hundred percent (100%) of the cost of the State and School Employees' Life and Health Insurance Plan created under Article 7, Chapter 15, Title 25, Mississippi Code of 1972, for all district employees who work no less than twenty (20) hours during each week and regular nonstudent school bus drivers employed by the district.

Where the use of federal funding is allowable to defray, in full or in part, the cost of participation in the insurance plan by district employees who work no less than twenty (20) hours during each week and regular nonstudent school bus drivers, whose salaries are paid, in full or in part, by federal funds, the allowance under this section shall be reduced to the extent of the federal funding. Where the use of federal funds is allowable but not available, it is the intent of the Legislature that school districts contribute the cost of participation for such employees from local funds, except that parent fees for child nutrition programs shall not be increased to cover such cost.

The State Department of Education, in accordance with rules and regulations established by the State Board of Education, may withhold a school district's adequate education program funds for failure of the district to timely report student, fiscal and personnel data necessary to meet state and/or federal requirements. The rules and regulations promulgated by the State Board of Education shall require the withholding of adequate education program funds for those districts that fail to remit premiums, interest penalties and/or late charges under the State and School Employees' Life and Health Insurance Plan. Noncompliance with such rules and regulations shall result in a violation of compulsory accreditation standards as established by the State Board of Education and Commission on School Accreditation.

SECTION 15. Section 41-7-173, Mississippi Code of 1972, is brought forward as follows:

41-7-173. For the purposes of Section 41-7-171 et seq., the following words shall have the meanings ascribed herein, unless the context otherwise requires:

(a) "Affected person" means (i) the applicant; (ii) a person residing within the geographic area to be served by the applicant's proposal; (iii) a person who regularly uses health care facilities or HMOs located in the geographic area of the proposal which provide similar service to that which is proposed; (iv) health care facilities and HMOs which have, prior to receipt of the application under review, formally indicated an intention to provide service similar to that of the proposal being considered at a future date; (v) third-party payers who reimburse health care facilities located in the geographical area of the proposal; or (vi) any agency that establishes rates for health care services or HMOs located in the geographic area of the proposal.

(b) "Certificate of need" means a written order of the State Department of Health setting forth the affirmative finding that a proposal in prescribed application form, sufficiently satisfies the plans, standards and criteria prescribed for such service or other project by Section 41-7-171 et seq., and by rules and regulations promulgated thereunder by the State Department of Health.

(c) (i) "Capital expenditure," when pertaining to defined major medical equipment, shall mean an expenditure which, under generally accepted accounting principles consistently applied, is not properly chargeable as an expense of operation and maintenance and which exceeds One Million Five Hundred Thousand Dollars ($1,500,000.00).

(ii) "Capital expenditure," when pertaining to other than major medical equipment, shall mean any expenditure which under generally accepted accounting principles consistently applied is not properly chargeable as an expense of operation and maintenance and which exceeds, for clinical health services, as defined in subsection (k) below, Five Million Dollars ($5,000,000.00), adjusted for inflation as published by the State Department of Health or which exceeds, for nonclinical health services, as defined in subsection (k) below, Ten Million Dollars ($10,000,000.00), adjusted for inflation as published by the State Department of Health.

(iii) A "capital expenditure" shall include the acquisition, whether by lease, sufferance, gift, devise, legacy, settlement of a trust or other means, of any facility or part thereof, or equipment for a facility, the expenditure for which would have been considered a capital expenditure if acquired by purchase. Transactions which are separated in time but are planned to be undertaken within twelve (12) months of each other and are components of an overall plan for meeting patient care

objectives shall, for purposes of this definition, be viewed in their entirety without regard to their timing.

(iv) In those instances where a health care facility or other provider of health services proposes to provide a service in which the capital expenditure for major medical equipment or other than major medical equipment or a combination of the two (2) may have been split between separate parties, the total capital expenditure required to provide the proposed service shall be considered in determining the necessity of certificate of need review and in determining the appropriate certificate of need review fee to be paid. The capital expenditure associated with facilities and equipment to provide services in Mississippi shall be considered regardless of where the capital expenditure was made, in state or out of state, and regardless of the domicile of the party making the capital expenditure, in state or out of state.

(d) "Change of ownership" includes, but is not limited to, inter vivos gifts, purchases, transfers, lease arrangements, cash and/or stock transactions or other comparable arrangements whenever any person or entity acquires or controls a majority interest of an existing health care facility, and/or the change of ownership of major medical equipment, a health service, or an institutional health service. Changes of ownership from partnerships, single proprietorships or corporations to another form of ownership are specifically included. However, "change of

ownership" shall not include any inherited interest acquired as a result of a testamentary instrument or under the laws of descent and distribution of the State of Mississippi.

(e) "Commencement of construction" means that all of the following have been completed with respect to a proposal or project proposing construction, renovating, remodeling or alteration:

(i) A legally binding written contract has been consummated by the proponent and a lawfully licensed contractor to construct and/or complete the intent of the proposal within a specified period of time in accordance with final architectural plans which have been approved by the licensing authority of the State Department of Health;

(ii) Any and all permits and/or approvals deemed lawfully necessary by all authorities with responsibility for such have been secured; and

(iii) Actual bona fide undertaking of the subject proposal has commenced, and a progress payment of at least one percent (1%) of the total cost price of the contract has been paid to the contractor by the proponent, and the requirements of this paragraph (e) have been certified to in writing by the State Department of Health.

Force account expenditures, such as deposits, securities, bonds, et cetera, may, in the discretion of the State Department

of Health, be excluded from any or all of the provisions of defined commencement of construction.

(f) "Consumer" means an individual who is not a provider of health care as defined in paragraph (q) of this section.

(g) "Develop," when used in connection with health services, means to undertake those activities which, on their completion, will result in the offering of a new institutional health service or the incurring of a financial obligation as defined under applicable state law in relation to the offering of such services.

(h) "Health care facility" includes hospitals, psychiatric hospitals, chemical dependency hospitals, skilled nursing facilities, end-stage renal disease (ESRD) facilities, including freestanding hemodialysis units, intermediate care facilities, ambulatory surgical facilities, intermediate care facilities for the mentally retarded, home health agencies, psychiatric residential treatment facilities, pediatric skilled nursing facilities, long-term care hospitals, comprehensive medical rehabilitation facilities, including facilities owned or operated by the state or a political subdivision or instrumentality of the state, but does not include Christian Science sanatoriums operated or listed and certified by the First Church of Christ, Scientist, Boston, Massachusetts. This definition shall not apply to facilities for the private practice,

either independently or by incorporated medical groups, of physicians, dentists or health care professionals except where such facilities are an integral part of an institutional health service. The various health care facilities listed in this paragraph shall be defined as follows:

(i) "Hospital" means an institution which is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment and care of injured, disabled or sick persons, or rehabilitation services for the rehabilitation of injured, disabled or sick persons. Such term does not include psychiatric hospitals.

(ii) "Psychiatric hospital" means an institution which is primarily engaged in providing to inpatients, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of persons with mental illness.

(iii) "Chemical dependency hospital" means an institution which is primarily engaged in providing to inpatients, by or under the supervision of a physician, medical and related services for the diagnosis and treatment of chemical dependency such as alcohol and drug abuse.

(iv) "Skilled nursing facility" means an institution or a distinct part of an institution which is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing

care or rehabilitation services for the rehabilitation of injured, disabled or sick persons.

(v) "End-stage renal disease (ESRD) facilities" means kidney disease treatment centers, which includes freestanding hemodialysis units and limited care facilities. The term "limited care facility" generally refers to an off-hospital-premises facility, regardless of whether it is provider or nonprovider operated, which is engaged primarily in furnishing maintenance hemodialysis services to stabilized patients.

(vi) "Intermediate care facility" means an institution which provides, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who, because of their mental or physical condition, require health-related care and services (above the level of room and board).

(vii) "Ambulatory surgical facility" means a facility primarily organized or established for the purpose of performing surgery for outpatients and is a separate identifiable legal entity from any other health care facility. Such term does not include the offices of private physicians or dentists, whether for individual or group practice, and does not include any abortion facility as defined in Section 41-75-1(f).

(viii) "Intermediate care facility for the mentally retarded" means an intermediate care facility that provides health or rehabilitative services in a planned program of activities to persons with an intellectual disability, also including, but not limited to, cerebral palsy and other conditions covered by the Federal Developmentally Disabled Assistance and Bill of Rights Act, Public Law 94-103.

(ix) "Home health agency" means a public or privately owned agency or organization, or a subdivision of such an agency or organization, properly authorized to conduct business in Mississippi, which is primarily engaged in providing to individuals at the written direction of a licensed physician, in the individual's place of residence, skilled nursing services provided by or under the supervision of a registered nurse licensed to practice in Mississippi, and one or more of the following services or items:

1. Physical, occupational or speech therapy;

2. Medical social services;

3. Part-time or intermittent services of a home health aide;

4. Other services as approved by the licensing agency for home health agencies;

5. Medical supplies, other than drugs and biologicals, and the use of medical appliances; or

6. Medical services provided by an intern or resident-in-training at a hospital under a teaching program of such hospital.

Further, all skilled nursing services and those services listed in items 1 through 4 of this subparagraph (ix) must be provided directly by the licensed home health agency. For purposes of this subparagraph, "directly" means either through an agency employee or by an arrangement with another individual not defined as a health care facility.

This subparagraph (ix) shall not apply to health care facilities which had contracts for the above services with a home health agency on January 1, 1990.

(x) "Psychiatric residential treatment facility" means any nonhospital establishment with permanent licensed facilities which provides a twenty-four-hour program of care by qualified therapists, including, but not limited to, duly licensed mental health professionals, psychiatrists, psychologists, psychotherapists and licensed certified social workers, for emotionally disturbed children and adolescents referred to such facility by a court, local school district or by the Department of Human Services, who are not in an acute phase of illness requiring the services of a psychiatric hospital, and are in need of such restorative treatment services. For purposes of this subparagraph, the term "emotionally disturbed" means a condition exhibiting one or more of the following characteristics over a

long period of time and to a marked degree, which adversely affects educational performance:

1. An inability to learn which cannot be explained by intellectual, sensory or health factors;

2. An inability to build or maintain satisfactory relationships with peers and teachers;

3. Inappropriate types of behavior or feelings under normal circumstances;

4. A general pervasive mood of unhappiness or depression; or

5. A tendency to develop physical symptoms or fears associated with personal or school problems. An establishment furnishing primarily domiciliary care is not within this definition.

(xi) "Pediatric skilled nursing facility" means an institution or a distinct part of an institution that is primarily engaged in providing to inpatients skilled nursing care and related services for persons under twenty-one (21) years of age who require medical or nursing care or rehabilitation services for the rehabilitation of injured, disabled or sick persons.

(xii) "Long-term care hospital" means a freestanding, Medicare-certified hospital that has an average length of inpatient stay greater than twenty-five (25) days, which is primarily engaged in providing chronic or long-term medical care to patients who do not require more than three (3) hours of

rehabilitation or comprehensive rehabilitation per day, and has a transfer agreement with an acute care medical center and a comprehensive medical rehabilitation facility. Long-term care hospitals shall not use rehabilitation, comprehensive medical rehabilitation, medical rehabilitation, sub-acute rehabilitation, nursing home, skilled nursing facility or sub-acute care facility in association with its name.

(xiii) "Comprehensive medical rehabilitation facility" means a hospital or hospital unit that is licensed and/or certified as a comprehensive medical rehabilitation facility which provides specialized programs that are accredited by the Commission on Accreditation of Rehabilitation Facilities and supervised by a physician board certified or board eligible in physiatry or other doctor of medicine or osteopathy with at least two (2) years of training in the medical direction of a comprehensive rehabilitation program that:

1. Includes evaluation and treatment of individuals with physical disabilities;

2. Emphasizes education and training of individuals with disabilities;

3. Incorporates at least the following core disciplines:

(i) Physical Therapy;

(ii) Occupational Therapy;

(iii) Speech and Language Therapy;

(iv) Rehabilitation Nursing; and

4. Incorporates at least three (3) of the following disciplines:

(i) Psychology;

(ii) Audiology;

(iii) Respiratory Therapy;

(iv) Therapeutic Recreation;

(v) Orthotics;

(vi) Prosthetics;

(vii) Special Education;

(viii) Vocational Rehabilitation;

(ix) Psychotherapy;

(x) Social Work;

(xi) Rehabilitation Engineering.

These specialized programs include, but are not limited to: spinal cord injury programs, head injury programs and infant and early childhood development programs.

(i) "Health maintenance organization" or "HMO" means a public or private organization organized under the laws of this state or the federal government which:

(i) Provides or otherwise makes available to enrolled participants health care services, including substantially the following basic health care services: usual physician services, hospitalization, laboratory, x-ray, emergency and preventive services, and out-of-area coverage;

(ii) Is compensated (except for copayments) for the provision of the basic health care services listed in subparagraph (i) of this paragraph to enrolled participants on a predetermined basis; and

(iii) Provides physician services primarily:

1. Directly through physicians who are either employees or partners of such organization; or

2. Through arrangements with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis).

(j) "Health service area" means a geographic area of the state designated in the State Health Plan as the area to be used in planning for specified health facilities and services and to be used when considering certificate of need applications to provide health facilities and services.

(k) "Health services" means clinically related (i.e., diagnostic, treatment or rehabilitative) services and includes alcohol, drug abuse, mental health and home health care services. "Clinical health services" shall only include those activities which contemplate any change in the existing bed complement of any health care facility through the addition or conversion of any beds, under Section 41-7-191(1)(c) or propose to offer any health services if those services have not been provided on a regular basis by the proposed provider of such services within the period of twelve (12) months prior to the time such services would be

offered, under Section 41-7-191(1)(d). "Nonclinical health services" shall be all other services which do not involve any change in the existing bed complement or offering health services as described above.

(l) "Institutional health services" shall mean health services provided in or through health care facilities and shall include the entities in or through which such services are provided.

(m) "Major medical equipment" means medical equipment designed for providing medical or any health-related service which costs in excess of One Million Five Hundred Thousand Dollars ($1,500,000.00). However, this definition shall not be applicable to clinical laboratories if they are determined by the State Department of Health to be independent of any physician's office, hospital or other health care facility or otherwise not so defined by federal or state law, or rules and regulations promulgated thereunder.

(n) "State Department of Health" or "department" shall mean the state agency created under Section 41-3-15, which shall be considered to be the State Health Planning and Development Agency, as defined in paragraph (u) of this section.

(o) "Offer," when used in connection with health services, means that it has been determined by the State Department of Health that the health care facility is capable of providing specified health services.

(p) "Person" means an individual, a trust or estate, partnership, corporation (including associations, joint-stock companies and insurance companies), the state or a political subdivision or instrumentality of the state.

(q) "Provider" shall mean any person who is a provider or representative of a provider of health care services requiring a certificate of need under Section 41-7-171 et seq., or who has any financial or indirect interest in any provider of services.

(r) "Radiation therapy services" means the treatment of cancer and other diseases using ionizing radiation of either high energy photons (x-rays or gamma rays) or charged particles (electrons, protons or heavy nuclei). However, for purposes of a certificate of need, radiation therapy services shall not include low energy, superficial, external beam x-ray treatment of superficial skin lesions.

(s) "Secretary" means the Secretary of Health and Human Services, and any officer or employee of the Department of Health and Human Services to whom the authority involved has been delegated.

(t) "State Health Plan" means the sole and official statewide health plan for Mississippi which identifies priority state health needs and establishes standards and criteria for health-related activities which require certificate of need review in compliance with Section 41-7-191.

(u) "State Health Planning and Development Agency" means the agency of state government designated to perform health planning and resource development programs for the State of Mississippi.

SECTION 16. Section 41-7-175, Mississippi Code of 1972, is brought forward as follows:

41-7-175. The State Department of Health shall be the sole and official agency of the State of Mississippi to administer and supervise, as prescribed by the Legislature, all responsibilities of the state health planning and development agency.

SECTION 17. Section 41-7-183, Mississippi Code of 1972, is brought forward as follows:

41-7-183. The State Department of Health shall have the duty of administering all functions and responsibilities of the designated state health planning and development agency as prescribed by the Legislature, and shall serve as the designated planning agency of the state for purposes of Section 1122 of Public Law 92-603 for the period of time that a contract is in effect between the Secretary and the State Department of Health for such purposes.

SECTION 18. Section 41-7-185, Mississippi Code of 1972, is brought forward as follows:

41-7-185. In carrying out its functions under Section 41-7-171 et seq., the State Department of Health is hereby empowered to:

(a) Make applications for and accept funds from the secretary and other federal and state agencies and to receive and administer such other funds for the planning or provision of health facilities or health care as are appropriate to the accomplishment of the purposes of Section 41-7-171 et seq.; and to contract with the secretary to accept funds to administer planning activities on the community, regional or state level;

(b) With the approval of the secretary, delegate to or contract with any mutually agreeable department, division or agency of the state, the federal government, or any political subdivision of either, or any private corporation, organization or association chartered by the Secretary of State of Mississippi, authority for administering any programs, duties or functions provided for in Section 41-7-171, et seq.;

(c) Prescribe and promulgate such reasonable rules and regulations as may be necessary to the implementation of the purposes of Section 41-7-171, et seq., complying with Section 25-43-1, et seq.;

(d) Require providers of institutional health services and home health care services provided through a home health agency and any other provider of health care requiring a certificate of need to submit or make available statistical information or such other information requested by the State Department of Health, but not information that would constitute an unwarranted invasion of the personal privacy of any individual

person or place the provider in jeopardy of legal action by a third party;

(e) Conduct such other hearing or hearings in addition to those provided for in Section 41-7-197, and enter such further order or orders, and with approval of the Governor enter into such agreement or agreements with the secretary as may be reasonably necessary to the realization by the people of Mississippi of the full benefits of Acts of Congress;

(f) In its discretion, contract with the secretary, or terminate any such contract, for the administration of the provisions, programs, duties and functions of Section 1122 of Public Law 92-603; but the State Department of Health shall not be relieved of matters of accountability, obligation or responsibility that accrued to the department by virtue of prior contracts and/or statutes;

(g) Prepare, review at least triennially, and revise, as necessary, a State Health Plan, as defined in Section 41-7-173, which shall be approved by the Governor before it becomes effective.

SECTION 19. Section 41-7-191, Mississippi Code of 1972, is brought forward as follows:

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

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

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

(c) Any change in the existing bed complement of any health care facility through the addition or conversion of any beds or the alteration, modernizing or refurbishing of any unit or department in which the beds may be located; however, if a health care facility has voluntarily delicensed some of its existing bed complement, it may later relicense some or all of its delicensed beds without the necessity of having to acquire a certificate of need. The State Department of Health shall maintain a record of the delicensing health care facility and its voluntarily delicensed beds and continue counting those beds as part of the state's total bed count for health care planning purposes. If a health care facility that has voluntarily delicensed some of its beds later desires to relicense some or all of its voluntarily delicensed beds, it shall notify the State Department of Health of

its intent to increase the number of its licensed beds. The State Department of Health shall survey the health care facility within thirty (30) days of that notice and, if appropriate, issue the health care facility a new license reflecting the new contingent of beds. However, in no event may a health care facility that has voluntarily delicensed some of its beds be reissued a license to operate beds in excess of its bed count before the voluntary delicensure of some of its beds without seeking certificate of need approval;

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

(i) Open-heart surgery services;

(ii) Cardiac catheterization services;

(iii) Comprehensive inpatient rehabilitation services;

(iv) Licensed psychiatric services;

(v) Licensed chemical dependency services;

(vi) Radiation therapy services;

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

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

(ix) Home health services;

(x) Swing-bed services;

(xi) Ambulatory surgical services;

(xii) Magnetic resonance imaging services;

(xiii) [Deleted]

(xiv) Long-term care hospital services;

(xv) Positron emission tomography (PET) services;

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

(f) The acquisition or otherwise control of any major medical equipment for the provision of medical services; however, (i) the acquisition of any major medical equipment used only for research purposes, and (ii) the acquisition of major medical equipment to replace medical equipment for which a facility is already providing medical services and for which the State

Department of Health has been notified before the date of such acquisition shall be exempt from this paragraph; an acquisition for less than fair market value must be reviewed, if the acquisition at fair market value would be subject to review;

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

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

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

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

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

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

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

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

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

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

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

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

(d) The State Department of Health may issue a certificate of need to any hospital located in DeSoto County for the new construction of a skilled nursing facility, not to exceed one hundred twenty (120) beds, in DeSoto County. From and after

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

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

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

(g) The State Department of Health may issue a certificate of need for the construction or expansion of nursing facility beds or the conversion of other beds to nursing facility beds in either Hinds, Madison or Rankin County, not to exceed

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

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

(i) The department may issue a certificate of need for the new construction of a skilled nursing facility in Leake County, provided that the recipient of the certificate of need agrees in writing that the skilled nursing facility will not at any time participate in the Medicaid program (Section 43-13-101 et seq.) or admit or keep any patients in the skilled nursing facility who are participating in the Medicaid program. This written agreement by the recipient of the certificate of need shall be fully binding on any subsequent owner of the skilled nursing facility, if the ownership of the facility is transferred at any time after the issuance of the certificate of need. Agreement that the skilled nursing facility will not participate in the Medicaid program shall be a condition of the issuance of a

certificate of need to any person under this paragraph (i), and if such skilled nursing facility at any time after the issuance of the certificate of need, regardless of the ownership of the facility, participates in the Medicaid program or admits or keeps any patients in the facility who are participating in the Medicaid program, the State Department of Health shall revoke the certificate of need, if it is still outstanding, and shall deny or revoke the license of the skilled nursing facility, at the time that the department determines, after a hearing complying with due process, that the facility has failed to comply with any of the conditions upon which the certificate of need was issued, as provided in this paragraph and in the written agreement by the recipient of the certificate of need. The provision of Section 41-7-193(1) regarding substantial compliance of the projection of need as reported in the current State Health Plan is waived for the purposes of this paragraph. The total number of nursing facility beds that may be authorized by any certificate of need issued under this paragraph (i) shall not exceed sixty (60) beds. If the skilled nursing facility authorized by the certificate of need issued under this paragraph is not constructed and fully operational within eighteen (18) months after July 1, 1994, the State Department of Health, after a hearing complying with due process, shall revoke the certificate of need, if it is still outstanding, and shall not issue a license for the skilled nursing

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

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

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

participation in the Medicaid program, and that no claim will be submitted for Medicaid reimbursement for more than thirty (30) patients in the facility in any month or for any patient in the facility who is in a bed that is not Medicaid-certified. This written agreement by the owner of the facility shall be a condition of licensure of the facility, and the agreement shall be fully binding on any subsequent owner of the facility if the ownership of the facility is transferred at any time after July 1, 2001. After this written agreement is executed, the Division of Medicaid and the State Department of Health shall not certify more than thirty (30) of the beds in the facility for participation in the Medicaid program. If the facility violates the terms of the written agreement by admitting or keeping in the facility on a regular or continuing basis more than thirty (30) patients who are participating in the Medicaid program, the State Department of Health shall revoke the license of the facility, at the time that the department determines, after a hearing complying with due process, that the facility has violated the written agreement.

(l) Provided that funds are specifically appropriated therefor by the Legislature, the department may issue a certificate of need to a rehabilitation hospital in Hinds County for the construction of a sixty-bed long-term care nursing facility dedicated to the care and treatment of persons with severe disabilities including persons with spinal cord and closed-head injuries and ventilator dependent patients. The

provisions of Section 41-7-193(1) regarding substantial compliance with projection of need as reported in the current State Health Plan are waived for the purpose of this paragraph.

(m) The State Department of Health may issue a certificate of need to a county-owned hospital in the Second Judicial District of Panola County for the conversion of not more than seventy-two (72) hospital beds to nursing facility beds, provided that the recipient of the certificate of need agrees in writing that none of the beds at the nursing facility will be certified for participation in the Medicaid program (Section 43-13-101 et seq.), and that no claim will be submitted for Medicaid reimbursement in the nursing facility in any day or for any patient in the nursing facility. This written agreement by the recipient of the certificate of need shall be a condition of the issuance of the certificate of need under this paragraph, and the agreement shall be fully binding on any subsequent owner of the nursing facility if the ownership of the nursing facility is transferred at any time after the issuance of the certificate of need. After this written agreement is executed, the Division of Medicaid and the State Department of Health shall not certify any of the beds in the nursing facility for participation in the Medicaid program. If the nursing facility violates the terms of the written agreement by admitting or keeping in the nursing facility on a regular or continuing basis any patients who are participating in the Medicaid program, the State Department of

Health shall revoke the license of the nursing facility, at the time that the department determines, after a hearing complying with due process, that the nursing facility has violated the condition upon which the certificate of need was issued, as provided in this paragraph and in the written agreement. If the certificate of need authorized under this paragraph is not issued within twelve (12) months after July 1, 2001, the department shall deny the application for the certificate of need and shall not issue the certificate of need at any time after the twelve-month period, unless the issuance is contested. If the certificate of need is issued and substantial construction of the nursing facility beds has not commenced within eighteen (18) months after July 1, 2001, the State Department of Health, after a hearing complying with due process, shall revoke the certificate of need if it is still outstanding, and the department shall not issue a license for the nursing facility at any time after the eighteen-month period. However, if the issuance of the certificate of need is contested, the department shall require substantial construction of the nursing facility beds within six (6) months after final adjudication on the issuance of the certificate of need.

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

facility will not at any time participate in the Medicaid program (Section 43-13-101 et seq.) or admit or keep any patients in the skilled nursing facility who are participating in the Medicaid program. This written agreement by the recipient of the certificate of need shall be fully binding on any subsequent owner of the skilled nursing facility, if the ownership of the facility is transferred at any time after the issuance of the certificate of need. Agreement that the skilled nursing facility will not participate in the Medicaid program shall be a condition of the issuance of a certificate of need to any person under this paragraph (n), and if such skilled nursing facility at any time after the issuance of the certificate of need, regardless of the ownership of the facility, participates in the Medicaid program or admits or keeps any patients in the facility who are participating in the Medicaid program, the State Department of Health shall revoke the certificate of need, if it is still outstanding, and shall deny or revoke the license of the skilled nursing facility, at the time that the department determines, after a hearing complying with due process, that the facility has failed to comply with any of the conditions upon which the certificate of need was issued, as provided in this paragraph and in the written agreement by the recipient of the certificate of need. The total number of nursing facility beds that may be authorized by any certificate of need issued under this paragraph (n) shall not exceed sixty (60) beds. If the certificate of need authorized under this paragraph

is not issued within twelve (12) months after July 1, 1998, the department shall deny the application for the certificate of need and shall not issue the certificate of need at any time after the twelve-month period, unless the issuance is contested. If the certificate of need is issued and substantial construction of the nursing facility beds has not commenced within eighteen (18) months after July 1, 1998, the State Department of Health, after a hearing complying with due process, shall revoke the certificate of need if it is still outstanding, and the department shall not issue a license for the nursing facility at any time after the eighteen-month period. However, if the issuance of the certificate of need is contested, the department shall require substantial construction of the nursing facility beds within six (6) months after final adjudication on the issuance of the certificate of need.

(o) The department may issue a certificate of need for the new construction, addition or conversion of skilled nursing facility beds in Leake County, provided that the recipient of the certificate of need agrees in writing that the skilled nursing facility will not at any time participate in the Medicaid program (Section 43-13-101 et seq.) or admit or keep any patients in the skilled nursing facility who are participating in the Medicaid program. This written agreement by the recipient of the certificate of need shall be fully binding on any subsequent owner of the skilled nursing facility, if the ownership of the facility

is transferred at any time after the issuance of the certificate of need. Agreement that the skilled nursing facility will not participate in the Medicaid program shall be a condition of the issuance of a certificate of need to any person under this paragraph (o), and if such skilled nursing facility at any time after the issuance of the certificate of need, regardless of the ownership of the facility, participates in the Medicaid program or admits or keeps any patients in the facility who are participating in the Medicaid program, the State Department of Health shall revoke the certificate of need, if it is still outstanding, and shall deny or revoke the license of the skilled nursing facility, at the time that the department determines, after a hearing complying with due process, that the facility has failed to comply with any of the conditions upon which the certificate of need was issued, as provided in this paragraph and in the written agreement by the recipient of the certificate of need. The total number of nursing facility beds that may be authorized by any certificate of need issued under this paragraph (o) shall not exceed sixty (60) beds. If the certificate of need authorized under this paragraph is not issued within twelve (12) months after July 1, 2001, the department shall deny the application for the certificate of need and shall not issue the certificate of need at any time after the twelve-month period, unless the issuance is contested. If the certificate of need is issued and substantial construction of the nursing facility beds has not commenced within eighteen (18)

months after July 1, 2001, the State Department of Health, after a hearing complying with due process, shall revoke the certificate of need if it is still outstanding, and the department shall not issue a license for the nursing facility at any time after the eighteen-month period. However, if the issuance of the certificate of need is contested, the department shall require substantial construction of the nursing facility beds within six (6) months after final adjudication on the issuance of the certificate of need.

(p) The department may issue a certificate of need for the construction of a municipally owned nursing facility within the Town of Belmont in Tishomingo County, not to exceed sixty (60) beds, provided that the recipient of the certificate of need agrees in writing that the skilled nursing facility will not at any time participate in the Medicaid program (Section 43-13-101 et seq.) or admit or keep any patients in the skilled nursing facility who are participating in the Medicaid program. This written agreement by the recipient of the certificate of need shall be fully binding on any subsequent owner of the skilled nursing facility, if the ownership of the facility is transferred at any time after the issuance of the certificate of need. Agreement that the skilled nursing facility will not participate in the Medicaid program shall be a condition of the issuance of a certificate of need to any person under this paragraph (p), and if such skilled nursing facility at any time after the issuance of

the certificate of need, regardless of the ownership of the facility, participates in the Medicaid program or admits or keeps any patients in the facility who are participating in the Medicaid program, the State Department of Health shall revoke the certificate of need, if it is still outstanding, and shall deny or revoke the license of the skilled nursing facility, at the time that the department determines, after a hearing complying with due process, that the facility has failed to comply with any of the conditions upon which the certificate of need was issued, as provided in this paragraph and in the written agreement by the recipient of the certificate of need. The provision of Section 41-7-193(1) regarding substantial compliance of the projection of need as reported in the current State Health Plan is waived for the purposes of this paragraph. If the certificate of need authorized under this paragraph is not issued within twelve (12) months after July 1, 1998, the department shall deny the application for the certificate of need and shall not issue the certificate of need at any time after the twelve-month period, unless the issuance is contested. If the certificate of need is issued and substantial construction of the nursing facility beds has not commenced within eighteen (18) months after July 1, 1998, the State Department of Health, after a hearing complying with due process, shall revoke the certificate of need if it is still outstanding, and the department shall not issue a license for the nursing facility at any time after the eighteen-month period.

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

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

(ii) Subject to the provisions of subparagraph (v), during each of the next four (4) fiscal years, the department shall issue six (6) certificates of need for new nursing facility beds, as follows: During fiscal years 2000, 2001 and 2002, one (1) certificate of need shall be issued for new nursing facility beds in the county in each of the four (4) Long-Term Care Planning Districts designated in the fiscal year 1999 State Health Plan that has the highest need in the district for those beds; and two (2) certificates of need shall be issued for new nursing facility beds in the two (2) counties from the state at large that have the highest need in the state for those beds, when considering the

need on a statewide basis and without regard to the Long-Term Care Planning Districts in which the counties are located. During fiscal year 2003, one (1) certificate of need shall be issued for new nursing facility beds in any county having a need for fifty (50) or more additional nursing facility beds, as shown in the fiscal year 1999 State Health Plan, that has not received a certificate of need under this paragraph (q) during the three (3) previous fiscal years. During fiscal year 2000, in addition to the six (6) certificates of need authorized in this subparagraph, the department also shall issue a certificate of need for new nursing facility beds in Amite County and a certificate of need for new nursing facility beds in Carroll County.

(iii) Subject to the provisions of subparagraph (v), the certificate of need issued under subparagraph (ii) for nursing facility beds in each Long-Term Care Planning District during each fiscal year shall first be available for nursing facility beds in the county in the district having the highest need for those beds, as shown in the fiscal year 1999 State Health Plan. If there are no applications for a certificate of need for nursing facility beds in the county having the highest need for those beds by the date specified by the department, then the certificate of need shall be available for nursing facility beds in other counties in the district in descending order of the need for those beds, from the county with the second highest need to

the county with the lowest need, until an application is received for nursing facility beds in an eligible county in the district.

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

(v) If a certificate of need is authorized to be issued under this paragraph (q) for nursing facility beds in a county on the basis of the need in the Long-Term Care Planning District during any fiscal year of the four-year period, a certificate of need shall not also be available under this

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

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

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

2. The county-owned hospital's qualifications for the certificate of need, as shown in its application and as

determined by the department, are at least equal to the qualifications of the other applicants for the certificate of need.

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

(ii) Not more than twenty (20) beds may be authorized by any certificate of need issued under this paragraph (r), and not more than a total of sixty (60) beds may be authorized in any Long-Term Care Planning District by all certificates of need issued under this paragraph (r). However, the total number of beds that may be authorized by all certificates of need issued under this paragraph (r) during any fiscal year shall not exceed one hundred twenty (120) beds, and the total number of beds that may be authorized in any Long-Term Care Planning District during any fiscal year shall not exceed forty (40) beds. Of the certificates of need that are issued for each Long-Term Care Planning District during the next two (2) fiscal years, at least one (1) shall be issued for beds in the northern part of the district, at least one (1) shall be issued

for beds in the central part of the district, and at least one (1) shall be issued for beds in the southern part of the district.

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

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

(t) The State Department of Health shall issue certificates of need to the owner of a nursing facility in operation at the time of Hurricane Katrina in Hancock County that

was not operational on December 31, 2005, because of damage sustained from Hurricane Katrina to authorize the following: (i) the construction of a new nursing facility in Harrison County; (ii) the relocation of forty-nine (49) nursing facility beds from the Hancock County facility to the new Harrison County facility; (iii) the establishment of not more than twenty (20) non-Medicaid nursing facility beds at the Hancock County facility; and (iv) the establishment of not more than twenty (20) non-Medicaid beds at the new Harrison County facility. The certificates of need that authorize the non-Medicaid nursing facility beds under subparagraphs (iii) and (iv) of this paragraph (t) shall be subject to the following conditions: The owner of the Hancock County facility and the new Harrison County facility must agree in writing that no more than fifty (50) of the beds at the Hancock County facility and no more than forty-nine (49) of the beds at the Harrison County facility will be certified for participation in the Medicaid program, and that no claim will be submitted for Medicaid reimbursement for more than fifty (50) patients in the Hancock County facility in any month, or for more than forty-nine (49) patients in the Harrison County facility in any month, or for any patient in either facility who is in a bed that is not Medicaid-certified. This written agreement by the owner of the nursing facilities shall be a condition of the issuance of the certificates of need under this paragraph (t), and the agreement shall be fully binding on any later owner or owners of either

facility if the ownership of either facility is transferred at any time after the certificates of need are issued. After this written agreement is executed, the Division of Medicaid and the State Department of Health shall not certify more than fifty (50) of the beds at the Hancock County facility or more than forty-nine (49) of the beds at the Harrison County facility for participation in the Medicaid program. If the Hancock County facility violates the terms of the written agreement by admitting or keeping in the facility on a regular or continuing basis more than fifty (50) patients who are participating in the Medicaid program, or if the Harrison County facility violates the terms of the written agreement by admitting or keeping in the facility on a regular or continuing basis more than forty-nine (49) patients who are participating in the Medicaid program, the State Department of Health shall revoke the license of the facility that is in violation of the agreement, at the time that the department determines, after a hearing complying with due process, that the facility has violated the agreement.

(u) The State Department of Health shall issue a certificate of need to a nonprofit venture for the establishment, construction and operation of a skilled nursing facility of not more than sixty (60) beds to provide skilled nursing care for ventilator dependent or otherwise medically dependent pediatric patients who require medical and nursing care or rehabilitation services to be located in a county in which an academic medical

center and a children's hospital are located, and for any construction and for the acquisition of equipment related to those beds. The facility shall be authorized to keep such ventilator dependent or otherwise medically dependent pediatric patients beyond age twenty-one (21) in accordance with regulations of the State Board of Health. For purposes of this paragraph (u), the provisions of Section 41-7-193(1) requiring substantial compliance with the projection of need as reported in the current State Health Plan are waived, and the provisions of Section 41-7-197 requiring a formal certificate of need hearing process are waived. The beds authorized by this paragraph shall be counted as pediatric skilled nursing facility beds for health planning purposes under Section 41-7-171 et seq. There shall be no prohibition of or restrictions on participation in the Medicaid program for the person receiving the certificate of need authorized by this paragraph.

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

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

(b) Of the total number of beds authorized under this subsection, the department may issue a certificate or certificates of need for the construction or expansion of psychiatric residential treatment facility beds or the conversion of other beds to psychiatric residential treatment facility beds in Warren County, not to exceed sixty (60) psychiatric residential treatment facility beds, provided that the facility agrees in writing that no more than thirty (30) of the beds at the psychiatric residential treatment facility will be certified for participation in the Medicaid program (Section 43-13-101 et seq.) for the use of any patients other than those who are participating only in the Medicaid program of another state, and that no claim will be submitted to the Division of Medicaid for Medicaid reimbursement for more than thirty (30) patients in the psychiatric residential treatment facility in any day or for any patient in the psychiatric residential treatment facility who is in a bed that is

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

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

(c) Of the total number of beds authorized under this subsection, the department shall issue a certificate of need to a hospital currently operating Medicaid-certified acute psychiatric beds for adolescents in DeSoto County, for the establishment of a forty-bed psychiatric residential treatment facility in DeSoto County, provided that the hospital agrees in writing (i) that the hospital shall give priority for the use of those forty (40) beds to Mississippi residents who are presently being treated in out-of-state facilities, and (ii) that no more than fifteen (15) of the beds at the psychiatric residential treatment facility will be certified for participation in the Medicaid program (Section 43-13-101 et seq.), and that no claim will be submitted for Medicaid reimbursement for more than fifteen (15) patients in the psychiatric residential treatment facility in any day or for any patient in the psychiatric residential treatment facility who is in a bed that is not Medicaid-certified. This written agreement by the recipient of the certificate of need shall be a condition of the issuance of the certificate of need under this paragraph, and the agreement shall be fully binding on any subsequent owner of the psychiatric residential treatment facility if the ownership of the facility is transferred at any time after the issuance of the certificate of need. After this written agreement is executed, the Division of Medicaid and the State Department of Health shall not certify more than fifteen (15) of the beds in the psychiatric residential treatment facility for participation in

the Medicaid program. If the psychiatric residential treatment facility violates the terms of the written agreement by admitting or keeping in the facility on a regular or continuing basis more than fifteen (15) patients who are participating in the Medicaid program, the State Department of Health shall revoke the license of the facility, at the time that the department determines, after a hearing complying with due process, that the facility has violated the condition upon which the certificate of need was issued, as provided in this paragraph and in the written agreement.

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

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

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

(f) The department shall issue a certificate of need to a one-hundred-thirty-four-bed specialty hospital located on twenty-nine and forty-four one-hundredths (29.44) commercial acres at 5900 Highway 39 North in Meridian (Lauderdale County), Mississippi, for the addition, construction or expansion of child/adolescent psychiatric residential treatment facility beds in Lauderdale County. As a condition of issuance of the certificate of need under this paragraph, the facility shall give priority in admissions to the child/adolescent psychiatric residential treatment facility beds authorized under this paragraph to patients who otherwise would require out-of-state placement. The Division of Medicaid, in conjunction with the Department of Human Services, shall furnish the facility a list of all out-of-state patients on a quarterly basis. Furthermore, notice shall also be provided to the parent, custodial parent or guardian of each out-of-state patient notifying them of the priority status granted by this paragraph. For purposes of this paragraph, the provisions of Section 41-7-193(1) requiring substantial compliance with the projection of need as reported in the current State Health Plan are waived. The total number of child/adolescent psychiatric residential treatment facility beds that may be authorized under the authority of this paragraph shall be sixty (60) beds. There shall be no prohibition or restrictions

on participation in the Medicaid program (Section 43-13-101 et seq.) for the person receiving the certificate of need authorized under this paragraph or for the beds converted pursuant to the authority of that certificate of need.

(4) (a) From and after March 25, 2021, the department may issue a certificate of need to any person for the new construction of any hospital, psychiatric hospital or chemical dependency hospital that will contain any child/adolescent psychiatric or child/adolescent chemical dependency beds, or for the conversion of any other health care facility to a hospital, psychiatric hospital or chemical dependency hospital that will contain any child/adolescent psychiatric or child/adolescent chemical dependency beds. There shall be no prohibition or restrictions on participation in the Medicaid program (Section 43-13-101 et seq.) for the person(s) receiving the certificate(s) of need authorized under this paragraph (a) or for the beds converted pursuant to the authority of that certificate of need. In issuing any new certificate of need for any child/adolescent psychiatric or child/adolescent chemical dependency beds, either by new construction or conversion of beds of another category, the department shall give preference to beds which will be located in an area of the state which does not have such beds located in it, and to a location more than sixty-five (65) miles from existing beds. Upon receiving 2020 census data, the department may amend the State Health Plan regarding child/adolescent psychiatric and

child/adolescent chemical dependency beds to reflect the need based on new census data.

(i) [Deleted]

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

(iii) The department may issue a certificate or certificates of need for the construction or expansion of child/adolescent psychiatric beds or the conversion of other beds to child/adolescent psychiatric beds in Warren County. For purposes of this subparagraph (iii), the provisions of Section 41-7-193(1) requiring substantial compliance with the projection of need as reported in the current State Health Plan are waived. The total number of beds that may be authorized under the authority of this subparagraph shall not exceed twenty (20) beds.

There shall be no prohibition or restrictions on participation in the Medicaid program (Section 43-13-101 et seq.) for the person receiving the certificate of need authorized under this subparagraph or for the beds converted pursuant to the authority of that certificate of need.

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

(iv) The department shall issue a certificate of need to the Region 7 Mental Health/Retardation Commission for the construction or expansion of child/adolescent psychiatric beds or the conversion of other beds to child/adolescent psychiatric beds in any of the counties served by the commission. For purposes of this subparagraph (iv), the provisions of Section 41-7-193(1) requiring substantial compliance with the projection of need as reported in the current State Health Plan are waived. The total number of beds that may be authorized under the authority of this

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

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

for participation in the Medicaid program or admits or keeps any Medicaid patients in such adult psychiatric beds, the State Department of Health shall revoke the certificate of need, if it is still outstanding, and shall deny or revoke the license of the hospital at the time that the department determines, after a hearing complying with due process, that the hospital has failed to comply with any of the conditions upon which the certificate of need was issued, as provided in this subparagraph and in the written agreement by the recipient of the certificate of need.

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

(b) From and after July 1, 1990, no hospital, psychiatric hospital or chemical dependency hospital shall be

authorized to add any child/adolescent psychiatric or child/adolescent chemical dependency beds or convert any beds of another category to child/adolescent psychiatric or child/adolescent chemical dependency beds without a certificate of need under the authority of subsection (1)(c) and subsection (4)(a) of this section.

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

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

certificate of need to any person under this subsection (6), and if such long-term care hospital at any time after the issuance of the certificate of need, regardless of the ownership of the facility, participates in the Medicaid program or admits or keeps any patients in the facility who are participating in the Medicaid program, the State Department of Health shall revoke the certificate of need, if it is still outstanding, and shall deny or revoke the license of the long-term care hospital, at the time that the department determines, after a hearing complying with due process, that the facility has failed to comply with any of the conditions upon which the certificate of need was issued, as provided in this subsection and in the written agreement by the recipient of the certificate of need. For purposes of this subsection, the provisions of Section 41-7-193(1) requiring substantial compliance with the projection of need as reported in the current State Health Plan are waived.

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

hospital meeting all federal requirements for participation in the swing-bed program which receives such certificate of need shall render services provided under the swing-bed concept to any patient eligible for Medicare (Title XVIII of the Social Security Act) who is certified by a physician to be in need of such services, and no such hospital shall permit any patient who is eligible for both Medicaid and Medicare or eligible only for Medicaid to stay in the swing beds of the hospital for more than thirty (30) days per admission unless the hospital receives prior approval for such patient from the Division of Medicaid, Office of the Governor. Any hospital having more licensed beds or a higher average daily census (ADC) than the maximum number specified in federal regulations for participation in the swing-bed program which receives such certificate of need shall develop a procedure to ensure that before a patient is allowed to stay in the swing beds of the hospital, there are no vacant nursing home beds available for that patient located within a fifty-mile radius of the hospital. When any such hospital has a patient staying in the swing beds of the hospital and the hospital receives notice from a nursing home located within such radius that there is a vacant bed available for that patient, the hospital shall transfer the patient to the nursing home within a reasonable time after receipt of the notice. Any hospital which is subject to the requirements of the two (2) preceding sentences of this subsection may be suspended from participation in the swing-bed program for a

reasonable period of time by the State Department of Health if the department, after a hearing complying with due process, determines that the hospital has failed to comply with any of those requirements.

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

(9) The Department of Health shall not grant approval for or issue a certificate of need to any person proposing the establishment of, or expansion of the currently approved territory of, or the contracting to establish a home office, subunit or

branch office within the space operated as a health care facility as defined in Section 41-7-173(h)(i) through (viii) by a health care facility as defined in subparagraph (ix) of Section 41-7-173(h).

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

(11) The new construction, renovation or expansion of or addition to any health care facility defined in subparagraph (ii) (psychiatric hospital), subparagraph (iv) (skilled nursing facility), subparagraph (vi) (intermediate care facility), subparagraph (viii) (intermediate care facility for the mentally retarded) and subparagraph (x) (psychiatric residential treatment facility) of Section 41-7-173(h) which is owned by the State of Mississippi and under the direction and control of the State Department of Mental Health, and the addition of new beds or the conversion of beds from one category to another in any such defined health care facility which is owned by the State of

Mississippi and under the direction and control of the State Department of Mental Health, shall not require the issuance of a certificate of need under Section 41-7-171 et seq., notwithstanding any provision in Section 41-7-171 et seq. to the contrary.

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

(13) The repair or the rebuilding of an existing, operating health care facility that sustained significant damage from a natural disaster that occurred after April 15, 2014, in an area that is proclaimed a disaster area or subject to a state of emergency by the Governor or by the President of the United States shall be exempt from all of the requirements of the Mississippi Certificate of Need Law (Section 41-7-171 et seq.) and any and all rules and regulations promulgated under that law, subject to the following conditions:

(a) The repair or the rebuilding of any such damaged health care facility must be within one (1) mile of the pre-disaster location of the campus of the damaged health care facility, except that any temporary post-disaster health care

facility operating location may be within five (5) miles of the pre-disaster location of the damaged health care facility;

(b) The repair or the rebuilding of the damaged health care facility (i) does not increase or change the complement of its bed capacity that it had before the Governor's or the President's proclamation, (ii) does not increase or change its levels and types of health care services that it provided before the Governor's or the President's proclamation, and (iii) does not rebuild in a different county; however, this paragraph does not restrict or prevent a health care facility from decreasing its bed capacity that it had before the Governor's or the President's proclamation, or from decreasing the levels of or decreasing or eliminating the types of health care services that it provided before the Governor's or the President's proclamation, when the damaged health care facility is repaired or rebuilt;

(c) The exemption from Certificate of Need Law provided under this subsection (13) is valid for only five (5) years from the date of the Governor's or the President's proclamation. If actual construction has not begun within that five-year period, the exemption provided under this subsection is inapplicable; and

(d) The Division of Health Facilities Licensure and Certification of the State Department of Health shall provide the same oversight for the repair or the rebuilding of the damaged health care facility that it provides to all health care facility construction projects in the state.

For the purposes of this subsection (13), "significant damage" to a health care facility means damage to the health care facility requiring an expenditure of at least One Million Dollars ($1,000,000.00).

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

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

(16) The State Department of Health shall issue any certificates of need necessary for Mississippi State University and a public or private health care provider to jointly acquire and operate a linear accelerator and a magnetic resonance imaging

unit. Those certificates of need shall cover all capital expenditures related to the project between Mississippi State University and the health care provider, including, but not limited to, the acquisition of the linear accelerator, the magnetic resonance imaging unit and other radiological modalities; the offering of linear accelerator and magnetic resonance imaging services; and the cost of construction of facilities in which to locate these services. The linear accelerator and the magnetic resonance imaging unit shall be (a) located in the City of Starkville, Oktibbeha County, Mississippi; (b) operated jointly by Mississippi State University and the public or private health care provider selected by Mississippi State University through a request for proposals (RFP) process in which Mississippi State University selects, and the Board of Trustees of State Institutions of Higher Learning approves, the health care provider that makes the best overall proposal; (c) available to Mississippi State University for research purposes two-thirds (2/3) of the time that the linear accelerator and magnetic resonance imaging unit are operational; and (d) available to the public or private health care provider selected by Mississippi State University and approved by the Board of Trustees of State Institutions of Higher Learning one-third (1/3) of the time for clinical, diagnostic and treatment purposes. For purposes of this subsection, the provisions of Section 41-7-193(1) requiring substantial compliance

with the projection of need as reported in the current State Health Plan are waived.

(17) The State Department of Health shall issue a certificate of need for the construction of an acute care hospital in Kemper County, not to exceed twenty-five (25) beds, which shall be named the "John C. Stennis Memorial Hospital." In issuing the certificate of need under this subsection, the department shall give priority to a hospital located in Lauderdale County that has two hundred fifteen (215) beds. For purposes of this subsection, the provisions of Section 41-7-193(1) requiring substantial compliance with the projection of need as reported in the current State Health Plan and the provisions of Section 41-7-197 requiring a formal certificate of need hearing process are waived. There shall be no prohibition or restrictions on participation in the Medicaid program (Section 43-13-101 et seq.) for the person or entity receiving the certificate of need authorized under this subsection or for the beds constructed under the authority of that certificate of need.

(18) The planning, design, construction, renovation, addition, furnishing and equipping of a clinical research unit at any health care facility defined in Section 41-7-173(h) that is under the direction and control of the University of Mississippi Medical Center and located in Jackson, Mississippi, and the addition of new beds or the conversion of beds from one (1) category to another in any such clinical research unit, shall not

require the issuance of a certificate of need under Section 41-7-171 et seq., notwithstanding any provision in Section 41-7-171 et seq. to the contrary.

(19) [Repealed]

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

(21) Nothing in this section or any other provision of Section 41-7-171 et seq. shall prevent any health care facility from the new construction, renovation, conversion or expansion of new beds in the facility designated as intensive care units, negative pressure rooms, or isolation rooms pursuant to the provisions of Sections 41-14-1 through 41-14-11, or Section 41-14-31. For purposes of this subsection, the provisions of Section 41-7-193(1) requiring substantial compliance with the projection of need as reported in the current State Health Plan and the provisions of Section 41-7-197 requiring a formal certificate of need hearing process are waived.

SECTION 20. Section 41-7-193, Mississippi Code of 1972, is brought forward as follows:

41-7-193. (1) No person may enter into any financing arrangement or commitment for financing a new institutional health service or any other project requiring a certificate of need

unless such certificate has been granted for such purpose. A certificate of need shall not be granted or issued to any person for any proposal, cause or reason, unless the proposal has been reviewed for consistency with the specifications and the criteria established by the State Department of Health and substantially complies with the projection of need as reported in the state health plan in effect at the time the application for the proposal was submitted.

(2) An application for a certificate of need for an institutional health service, medical equipment or any proposal requiring a certificate of need shall specify the time, within that granted, such shall be functional or operational according to a time schedule submitted with the application. Each certificate of need shall specify the maximum amount of capital expenditure that may be obligated. The State Department of Health shall periodically review the progress and time schedule of any person issued or granted a certificate of need for any purpose.

(3) An application for a certificate of need may be filed at any time with the department after the applicant has given the department fifteen (15) days' written notice of its intent to apply for a certificate of need. The department shall not delay review of an application. The department shall make its recommendation approving or disapproving a complete application within forty-five (45) days of the date the application was filed or within fifteen (15) days of receipt of any requested

information, whichever is later, said request to be made by the department within fifteen (15) days of the filing of the application.

SECTION 21. Section 83-9-22, Mississippi Code of 1972, is brought forward as follows:

83-9-22. (1) (a) Notwithstanding any other provision of the law to the contrary, except as otherwise provided in subsection (3) of this section, no health coverage plan shall restrict coverage for medically appropriate treatment prescribed by a physician and agreed to by a fully informed insured, or if the insured lacks legal capacity to consent by a person who has legal authority to consent on his or her behalf, based on an insured's diagnosis with a terminal condition. Refusing to pay for treatment rendered to an insured near the end of life that is consistent with best practices for treatment of a disease or condition, approved uses of a drug or device, or uses supported by peer reviewed medical literature, is a per se violation of this section.

(b) Violations of this section shall constitute an unfair trade practice and subject the violator to the penalties provided by law.

(c) As used in this section "terminal condition" means any aggressive malignancy, chronic end-stage cardiovascular or cerebral vascular disease, or any other disease, illness or condition which a physician diagnoses as terminal.

(d) As used in this section, a "health coverage plan" shall mean any hospital, health or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, contract or agreement with a health maintenance organization or a preferred provider organization, health and accident insurance policy, or any other insurance contract of this type, including a group insurance plan and the State Health and Life Insurance Plan.

(2) (a) Notwithstanding any other provision of the law to the contrary, no health benefit paid directly or indirectly with state funds, specifically Medicaid, shall restrict coverage for medically appropriate treatment prescribed by a physician and agreed to by a fully informed individual, or if the individual lacks legal capacity to consent by a person who has legal authority to consent on his or her behalf, based on an individual's diagnosis with a terminal condition.

(b) Refusing to pay for treatment rendered to an individual near the end of life that is consistent with best practices for treatment of a disease or condition, approved uses of a drug or device, or uses supported by peer reviewed medical literature, is a per se violation of this section.

(c) As used in this section "terminal condition" means any aggressive malignancy, chronic end-stage cardiovascular or cerebral vascular disease, or any other disease, illness or condition which a physician diagnoses as terminal.

(3) This section does not require a health coverage plan to cover and pay for the treatment of a person who is a cardholder and registered qualifying patient with medical cannabis that is lawful under the Mississippi Medical Cannabis Act and in compliance with rules and regulations adopted thereunder.

SECTION 22. Section 83-9-24, Mississippi Code of 1972, is brought forward as follows:

83-9-24. (1) (a) As used in this section, the following terms shall be defined as provided in this subsection:

(b) "Anti-cancer medication" means drugs and biologics that are used to kill, slow, or prevent the growth of cancerous cells.

(c) "Health plan or policy" means any hospital, health or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, contract or agreement with a health maintenance organization or a preferred provider organization, health and accident insurance policy, or any other insurance contract of this type, including a group insurance plan and the State and School Employees Life and Health Insurance Plan.

(2) Any health plan or policy delivered, issued for delivery or renewed in this state on or after January 1, 2016, that covers anti-cancer medications that are injected or intravenously administered by a health care provider and patient-administered anti-cancer medications, including, but not limited to, those orally administered or self-injected, may not require a higher

co-payment, deductible or coinsurance amount for patient-administered anti-cancer medications than it requires for injected or intravenously administered anti-cancer medications, regardless of the formulation or benefit category determination by the policy or plan.

(3) The health insurance policy or plan may not comply with subsection (2) of this section by:

(a) Increasing the co-payment, deductible or coinsurance amount required for injected or intravenously administered anti-cancer medications that are covered under the policy or plan; or

(b) Reclassifying benefits with respect to anti-cancer medications.

SECTION 23. This act shall take effect and be in force from and after July 1, 2023.