MISSISSIPPI LEGISLATURE REGULAR SESSION 1999

By: Senator(s) Bean

To: Public Health and Welfare

COMMITTEE SUBSTITUTE
FOR
SENATE BILL NO. 2143

AN ACT RELATING TO MEDICAID ASSISTANCE; TO AMEND SECTIONS 43-13-103 AND 43-13-105, MISSISSIPPI CODE OF 1972, TO AUTHORIZE THE DIVISION OF MEDICAID TO EXPEND FUNDS UNDER TITLE XXI OF THE FEDERAL SOCIAL SECURITY ACT; TO AMEND SECTION 43-13-111, MISSISSIPPI CODE OF 1972, TO CLARIFY THAT EACH STATE AGENCY SHALL REQUEST AND OBTAIN AN APPROPRIATION FOR ALL MEDICAID PROGRAMS ADMINISTERED BY SUCH AGENCY; TO AMEND SECTION 43-13-113, MISSISSIPPI CODE OF 1972, TO REQUIRE THE DIVISION OF MEDICAID AND ITS FISCAL AGENT TO IMPLEMENT A CONTINGENCY REIMBURSEMENT AND ELIGIBILITY VERIFICATION PLAN IN THE EVENT OF A YEAR 2000 PROBLEM; TO AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972, TO DEFINE THOSE INDIVIDUALS ELIGIBLE FOR MEDICAID ASSISTANCE; TO AMEND SECTION 43-13-116, MISSISSIPPI CODE OF 1972, TO PROVIDE FOR LOCAL AND STATE HEARING REQUESTS BY CLAIMANTS; TO AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO DELETE THE REQUIREMENT FOR DIVISION OF MEDICAID APPROVAL FOR REIMBURSEMENT FOR MORE THAN 15 DAYS OF INPATIENT HOSPITAL CARE, TO DIRECT THE DIVISION TO DEVELOP A COST-TO-CHARGE RATIO CALCULATIONS FOR OUTPATIENT HOSPITAL SERVICES, TO INCREASE THE AUTHORIZED NUMBER OF HOME LEAVE DAYS FOR NURSING FACILITY SERVICES AND ICFMR SERVICES REIMBURSEMENT, TO DELETE THE REPEALER ON THE CASE-MIX REIMBURSEMENT SYSTEM FOR NURSING FACILITY SERVICES, TO AUTHORIZE THE DIVISION TO REDUCE THE PAYMENT FOR HOSPITAL LEAVE AND HOME LEAVE FOR A NURSING FACILITY RESIDENT USING CERTAIN CASE-MIX CRITERIA AND TO AUTHORIZE THE DIVISION TO LIMIT CERTAIN MANAGEMENT FEES AND HOME OFFICE COSTS FOR NURSING FACILITIES, ICFMR'S AND PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES, TO DELETE CERTAIN REQUIREMENTS FOR REIMBURSEMENT TO NURSING FACILITIES FOR RETURN ON EQUITY CAPITAL, TO DELETE THE PROVISION ESTABLISHING AND EMPOWERING THE MEDICAID REVIEW BOARD FOR NURSING FACILITIES, TO REQUIRE A NURSING FACILITY PREADMISSION SCREENING PROGRAM FOR MEDICAID BENEFICIARIES AND APPLICANTS, TO AUTHORIZE A CASE-MIX REIMBURSEMENT ADD-ON AND DEPRECIATION REIMBURSEMENT FOR RESIDENTS OF NURSING FACILITIES WITH ALZHEIMER'S OR RELATED DEMENTIA, TO PROVIDE FOR A PREADMISSION SCREENING TEAM, TO PROVIDE MEDICAID REIMBURSEMENT FOR PREADMISSION SCREENING SERVICES AND TO DELETE THE REQUIREMENT THAT THE DIVISION OF MEDICAID PROVIDE HOME- AND COMMUNITY-BASED SERVICES UNDER A COOPERATIVE AGREEMENT WITH THE DEPARTMENT OF HUMAN SERVICES, TO INCREASE THE PHYSICIAN'S FEE AND DENTIST'S FEE REIMBURSEMENT UNDER MEDICAID, TO AUTHORIZE THE DIVISION TO REQUIRE HOME HEALTH SERVICES PROVIDERS TO OBTAIN A SURETY BOND, TO AUTHORIZE THE DIVISION TO REQUIRE DURABLE MEDICAL EQUIPMENT PROVIDERS TO OBTAIN A SURETY BOND AND TO DELETE THE LIMITATION ON DURABLE MEDICAL EQUIPMENT REIMBURSEMENT, TO AUTHORIZE THE DIVISION TO REQUIRE INDIVIDUALS TO ENROLL IN A MEDICAID MANAGED CARE PROGRAM, TO ESTABLISH A MANAGED CARE MARKETING ADVISORY COMMITTEE TO AUTHORIZE MEDICAID REIMBURSEMENT FOR ONE PAIR OF EYEGLASSES EVERY FIVE YEARS, TO DELETE THE AUTHORITY FOR THE PERSONAL CARE SERVICES PILOT PROGRAM, TO DELETE THE REPEALER ON THE PROVISION FOR CHIROPRACTIC SERVICES REIMBURSEMENT, TO CHANGE THE DATE FOR CHANGES IN REIMBURSEMENT RATES REQUIRING LEGISLATIVE APPROVAL, TO DIRECT THE DIVISION TO PAY MEDICARE COST SHARING FOR QUALIFIED

MEDICAID BENEFICIARIES; TO AMEND SECTION 43-13-121, MISSISSIPPI CODE OF 1972, TO PROVIDE FOR ACCESS TO PROVIDER RECORDS FOR DIVISION STAFF AND TO DISQUALIFY CERTAIN PROVIDERS FOR REIMBURSEMENT; TO AMEND SECTION 43-13-122, MISSISSIPPI CODE OF 1972, IN CONFORMITY THERETO; TO AMEND SECTION 43-13-125, MISSISSIPPI CODE OF 1972, TO CLARIFY THAT THE DIVISION OF MEDICAID'S SUBROGATION RIGHTS ARE TO THE EXTENT OF BENEFITS PROVIDED BY MEDICAID ON BEHALF OF THE RECIPIENT TO WHOM THIRD PARTY PAYMENTS ARE PAYABLE; TO AMEND SECTION 43-13-137, MISSISSIPPI CODE OF 1972, TO DIRECT THE DIVISION OF MEDICAID TO COMPLY WITH THE ADMINISTRATIVE PROCEDURES ACT; TO AMEND SECTION 43-13-305, MISSISSIPPI CODE OF 1972, TO AUTHORIZE THE DIVISION OF MEDICAID TO ENDORSE MULTI-PAYEE CHECKS; AND FOR RELATED PURPOSES.

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

SECTION 1. Section 43-13-103, Mississippi Code of 1972, is amended as follows:

43-13-103. For the purpose of affording health care and remedial and institutional services in accordance with the requirements for federal grants and other assistance under Titles XVIII, XIX and XXI of the Social Security Act, as amended, a statewide system of medical assistance is hereby established and shall be in effect in all political subdivisions of the state, to be financed by state appropriations and federal matching funds therefor, and to be administered by the Office of the Governor as hereinafter provided.

SECTION 2. Section 43-13-105, Mississippi Code of 1972, is amended as follows:

43-13-105. When used in this article, the following definitions shall apply, unless the context requires otherwise:

(a) "Administering agency" means the Division of Medicaid in the Office of the Governor as created by this article.

(b) "Division" or "Division of Medicaid" means the Division of Medicaid in the Office of the Governor.

(c) "Medical assistance" means payment of part or all of the costs of medical and remedial care provided under the terms of this article and in accordance with provisions of Titles XIX and XXI of the Social Security Act, as amended.

(d) "Applicant" means a person who applies for assistance under Titles IV, XVI, XIX or XXI of the Social Security Act, as amended, and under the terms of this article.

(e) "Recipient" means a person who is eligible for assistance under Title XIX or XXI of the Social Security Act, as amended and under the terms of this article.

(f) "State health agency" shall mean any agency,

department, institution, board or commission of the State of Mississippi, except the University Medical School, which is supported in whole or in part by any public funds, including funds directly appropriated from the State Treasury, funds derived by taxes, fees levied or collected by statutory authority, or any other funds used by "state health agencies" derived from federal sources, when any funds available to such agency are expended either directly or indirectly in connection with, or in support of, any public health, hospital, hospitalization or other public programs for the preventive treatment or actual medical treatment of persons who are physically or mentally ill or mentally retarded.

(g) "Mississippi Medicaid Commission" or "Medicaid Commission" wherever they appear in the laws of the State of Mississippi, shall mean the Division of Medicaid in the Office of the Governor.

SECTION 3. Section 43-13-111, Mississippi Code of 1972, is amended as follows:

43-13-111. <u>Every state health agency, as defined in Section 43-13-105, shall obtain an appropriation of state funds from the state Legislature for all medical assistance programs rendered by the agency and shall organize its programs and budgets in such a manner as to secure maximum federal funding through the Division of Medicaid under Title XIX or Title XXI of the federal Social Security Act, as amended.</u> SECTION 4. Section 43-13-113, Mississippi Code of 1972, is amended as follows:

43-13-113. (1) The State Treasurer is hereby authorized and directed to receive on behalf of the state, and to execute all instruments incidental thereto, federal and other funds to be used for financing the medical assistance plan or program adopted pursuant to this article, and to place all such funds in a special account to the credit of the Governor's Office-Division of Medicaid, which said funds shall be expended by the division for

the purposes and under the provisions of this article, and shall be paid out by the State Treasurer as funds appropriated to carry out the provisions of this article are paid out by him.

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

(2) Disbursement of funds to providers shall be made as follows:

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

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

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

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

(e) If a claim is neither paid nor denied for valid and proper reasons by the end of the time periods as specified above, the Division of Medicaid's fiscal agent must pay the provider interest on the claim at the rate of one and one-half percent (1-1/2%) per month on the amount of such claim until it is finally settled or adjudicated.

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

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

(5) The above specified time limitations do not apply in the following circumstances:

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

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

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

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

(6) <u>The Division of Medicaid and its fiscal agent shall develop a contingency plan for reimbursement and eligibility verification to be used in the event that on January 1, 2000, the computers and computer programs used by the Division of Medicaid</u>

and its fiscal agent have not been sufficiently modified to deal with the issues that will result because of the year 2000. Such contingency plan (a) must be ready to be implemented immediately upon the realization of a year 2000 problem, (b) must be developed so there will be no delay of eligibility verification or reimbursement resulting from such year 2000 problem, and (c) must include a periodic interim payment system for each Medicaid provider that will be immediately implemented, regardless of the purported effectiveness of the conversion process, should such conversion process or the lack thereof result in a Medicaid remittance payment to a Medicaid provider for two (2) payment cycles that is less than seventy percent (70%) of the average remittance to that provider during state fiscal 1999. A draft of the contingency plan and a summary thereof must be available for review and comment by Medicaid providers no later than July 1, 1999. The Medicaid providers shall be entitled to submit written, substantive comments to the Division of Medicaid no later than September 1, 1999, regarding such contingency plan, which plan must be finalized no later than October 1, 1999, whereupon the Division of Medicaid shall then make available the contingency plan and a summary thereof to all Medicaid providers.

(7) If sufficient funds are appropriated therefor by the Legislature, the Division of Medicaid may contract with the Mississippi Dental Association, or an approved designee, to develop and operate a Donated Dental Services (DDS) program through which volunteer dentists will treat needy disabled, aged and medically-compromised individuals who are non-Medicaid eligible recipients.

SECTION 5. Section 43-13-115, Mississippi Code of 1972, is amended as follows:

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

(1) Who are qualified for public assistance grants under provisions of Title IV-A and E of the federal Social Security Act,

as amended, as determined by the State Department of Human Services, including those statutorily deemed to be IV-A as determined by the State Department of Human Services and certified to the Division of Medicaid, but not optional groups except as specifically covered in this section. For the purposes of this paragraph (1) and paragraphs * * * (8), * * * (17) and (18) of this section, any reference to Title IV-A or to Part A of Title IV of the federal Social Security Act, as amended, or the state plan under Title IV-A or Part A of Title IV, shall be considered as a reference to Title IV-A of the federal Social Security Act, as amended, and the state plan under Title IV-A, including the income and resource standards and methodologies under Title IV-A and the state plan, as they existed on July 16, 1996.

(2) Those qualified for Supplemental Security Income (SSI) benefits under Title XVI of the federal Social Security Act, as amended. The eligibility of individuals covered in this paragraph shall be determined by the Social Security Administration and certified to the Division of Medicaid.

(3) * * *

(4) * * *

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

(6) Children certified by the State Department of Human Services to the Division of Medicaid of whom the state and county

human services agency has custody and financial responsibility, and children who are in adoptions subsidized in full or part by the Department of Human Services, who are approvable under Title XIX of the Medicaid program.

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

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

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

(9) Individuals who are:

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

(b) Pregnant women, infants and children who have not attained the age of six (6), with family income that does not

exceed one hundred thirty-three percent (133%) of the federal poverty level; and

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

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

(10) Certain disabled children age eighteen (18) or under who are living at home, who would be eligible, if in a medical institution, for SSI or a state supplemental payment under Title XVI of the federal Social Security Act, as amended, and therefore for Medicaid under the plan, and for whom the state has made a determination as required under Section 1902(e)(3)(b) of the federal Social Security Act, as amended. The eligibility of individuals under this paragraph shall be determined by the Division of Medicaid.

(11) Individuals who are sixty-five (65) years of age or older or are disabled as determined under Section 1614(a)(3) of the federal Social Security Act, as amended, and who meet the following criteria:

(a) Whose income does not exceed one hundred percent (100%) of the nonfarm official poverty line as defined by the Office of Management and Budget and revised annually.

(b) Whose resources do not exceed <u>two hundred percent (200%) of the amount</u> allowed under the Supplemental Security Income (SSI) program.

The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid, and such individuals determined eligible shall receive the same Medicaid services as other categorical eligible individuals.

(12) Individuals who are qualified Medicare beneficiaries (QMB) entitled to Part A Medicare as defined under Section 301, Public Law 100-360, known as the Medicare Catastrophic Coverage

Act of 1988, and who meet the following criteria:

* * * Whose income does not exceed one hundred percent (100%) of the nonfarm official poverty line as defined by the Office of Management and Budget and revised annually.

* * *

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

(13) (a) Individuals who are entitled to Medicare Part A as defined in Section 4501 of the Omnibus Budget Reconciliation Act of 1990, and * * * whose income does not exceed the percentage of the nonfarm official poverty line as defined by the Office of Management and Budget and revised annually which, on or after:

(i) January 1, 1993, is one hundred ten percent (110%); and

(ii) January 1, 1995, is one hundred twenty percent (120%).

(b) Individuals entitled to Part A of Medicare, with income above one hundred twenty percent (120%), but less than one hundred thirty-five percent (135%) of the federal poverty level, and not otherwise eligible for Medicaid. Eligibility for Medicaid benefits is limited to full payment of Medicare Part B premiums. The number of eligible individuals is limited by the availability of the federal capped allocation at one hundred percent (100%) of federal matching funds, as more fully defined in the Balanced Budget Act of 1997.

(c) Individuals entitled to Part A of Medicare, with income of at least one hundred thirty-five percent (135%), but not exceeding one hundred seventy-five percent (175%) of the federal poverty level, and not otherwise eligible for Medicaid. Eligibility for Medicaid benefits is limited to partial payment of

Medicare Part B premiums. The number of eligible individuals is limited by the availability of the federal capped allocation of one hundred percent (100%) federal matching funds, as more fully defined in the Balanced Budget Act of 1997.

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

(14) * * *

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

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

(17) In accordance with the terms of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193), persons who become ineligible for assistance under Title IV-A of the federal Social Security Act, as amended because of increased income from or hours of employment of the caretaker relative or because of the expiration of the applicable earned income disregards, who were eligible for Medicaid for at least three (3) of the six (6) months preceding the month in which such ineligibility begins, shall be eligible for Medicaid assistance for up to twenty-four (24) months; however, Medicaid assistance for more than twelve (12) months may be provided only if a federal waiver is obtained to provide such assistance for

more than twelve (12) months and federal and state funds are available to provide such assistance.

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

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

SECTION 6. Section 43-13-116, Mississippi Code of 1972, is amended as follows:

43-13-116. (1) It shall be the duty of the Division of Medicaid to fully implement and carry out the administrative functions of determining the eligibility of those persons who qualify for medical assistance under Section 43-13-115.

(2) In determining Medicaid eligibility, the Division of Medicaid is authorized to enter into an agreement with the Secretary of the Department of Health and Human Services for the purpose of securing the transfer of eligibility information from the Social Security Administration on those individuals receiving supplemental security income benefits under the federal Social Security Act and any other information necessary in determining Medicaid eligibility. The Division of Medicaid is further empowered to enter into contractual arrangements with its fiscal agent or with the State Department of Human Services in securing electronic data processing support as may be necessary.

(3) Administrative hearings shall be available to any

applicant who requests it because his or her claim of eligibility for services is denied or is not acted upon with reasonable promptness or by any recipient who requests it because he or she believes the agency has erroneously taken action to deny, reduce, or terminate benefits. The agency need not grant a hearing if the sole issue is a federal or state law requiring an automatic change adversely affecting some or all recipients. Eligibility determinations that are made by other agencies and certified to the Division of Medicaid pursuant to Section 43-13-115 are not subject to the administrative hearing procedures of the Division of Medicaid but are subject to the administrative hearing procedures of the agency that determined eligibility.

(a) A request may be made either for a local regional office hearing or a state office hearing when the local regional office has made the initial decision that the claimant seeks to appeal or when the regional office has not acted with reasonable promptness in making a decision on a claim for eligibility or services. The only exception to requesting a local hearing is when the issue under appeal involves either (i) a disability or blindness denial, or termination, or (ii) a level of care denial or termination for a disabled child living at home. An appeal involving disability, blindness or level of care must be handled as a state level hearing. The decision from the local hearing may be appealed to the state office for a state hearing. A decision to deny, reduce or terminate benefits that is initially made at the state office may be appealed by requesting a state hearing.

(b) A request for a hearing, either state or local, must be made in writing by the claimant or claimant's legal representative. "Legal representative" includes the claimant's authorized representative, an attorney retained by the claimant or claimant's family to represent the claimant, a paralegal representative with a legal aid services, a parent of a minor child if the claimant is a child, a legal guardian or conservator or an individual with power of attorney for the claimant. The

claimant may also be represented by anyone that he or she so designates but must give the designation to the Medicaid regional office or state office in writing, if the person is not the legal representative, legal guardian, or authorized representative.

(c) The claimant may make a request for a hearing in person at the regional office but an oral request must be put into written form. Regional office staff will determine from the claimant if a local or state hearing is requested and assist the claimant in completing and signing the appropriate form. Regional office staff may forward a state hearing request to the appropriate division in the state office or the claimant may mail the form to the address listed on the form. The claimant may make a written request for a hearing by letter. A simple statement requesting a hearing that is signed by the claimant or legal representative is sufficient; however, if possible, the claimant should state the reason for the request. The letter may be mailed to the regional office or it may be mailed to the state office. If the letter does not specify the type of hearing desired, local or state, Medicaid staff will attempt to contact the claimant to determine the level of hearing desired. If contact cannot be made within three (3) days of receipt of the request, the request will be assumed to be for a local hearing and scheduled accordingly. A hearing will not be scheduled until either a letter or the appropriate form is received by the regional or state office.

(d) When both members of a couple wish to appeal an action or inaction by the agency that affects both applications or cases similarly and arose from the same issue, one or both may file the request for hearing, both may present evidence at the hearing, and the agency's decision will be applicable to both. If both file a request for hearing, two (2) hearings will be registered but they will be conducted on the same day and in the same place, either consecutively or jointly, as the couple wishes. If they so desire, only one of the couple need attend the hearing.

(e) The procedure for administrative hearings shall be

as follows:

(i) The claimant has thirty (30) days from the date the agency mails the appropriate notice to the claimant of its decision regarding eligibility, services, or benefits to request either a state or local hearing. This time period may be extended if the claimant can show good cause for not filing within thirty (30) days. Good cause includes, but may not be limited to, illness, failure to receive the notice, being out of state, or some other reasonable explanation. If good cause can be shown, a late request may be accepted provided the facts in the case remain the same. If a claimant's circumstances have changed or if good cause for filing a request beyond thirty (30) days is not shown, a hearing request will not be accepted. If the claimant wishes to have eligibility reconsidered, he or she may reapply.

(ii) If a claimant or representative requests a hearing in writing during the advance notice period before benefits are reduced or terminated, benefits must be continued or reinstated to the benefit level in effect before the effective date of the adverse action. Benefits will continue at the original level until the final hearing decision is rendered. Any hearing requested after the advance notice period will not be accepted as a timely request in order for continuation of benefits to apply.

(iii) Upon receipt of a written request for a hearing, the request will be acknowledged in writing within twenty (20) days and a hearing scheduled. The claimant or representative will be given at least five (5) days' advance notice of the hearing date. <u>The local and/or state level hearings will be held by telephone unless, at the hearing officer's discretion, it is determined that an in-person hearing is necessary.</u> If a local hearing is requested, the regional office will notify the claimant or representative in writing of the time * * * of the local hearing. If a state hearing is requested, the state office will notify the claimant or representative in writing of the time * * *

of the state hearing. If an in-person hearing is necessary, local hearings will be held at the regional office and state hearings will be held at the state office unless other arrangements are necessitated by the claimant's inability to travel.

(iv) All persons attending a hearing will attend for the purpose of giving information on behalf of the claimant or rendering the claimant assistance in some other way, or for the purpose of representing the Division of Medicaid.

(v) A state or local hearing request may be withdrawn at any time before the scheduled hearing, or after the hearing is held but before a decision is rendered. The withdrawal must be in writing and signed by the claimant or representative. A hearing request will be considered abandoned if the claimant or representative fails to appear at a scheduled hearing without good cause. If no one appears for a hearing, the appropriate office will notify the claimant in writing that the hearing is dismissed unless good cause is shown for not attending. The proposed agency action will be taken on the case following failure to appear for a hearing if the action has not already been effected.

(vi) The claimant or his representative has the following rights in connection with a local or state hearing:

(A) The right to examine at a reasonable time before the date of the hearing and during the hearing the content of the claimant's case record;

(B) The right to have legal representation at the hearing and to bring witnesses;

(C) The right to produce documentary evidence and establish all facts and circumstances concerning eligibility, services, or benefits;

(D) The right to present an argument without undue interference;

(E) The right to question or refute any testimony or evidence including an opportunity to confront and cross-examine adverse witnesses.

(vii) When a request for a local hearing is received by the regional office or if the regional office is notified by the state office that a local hearing has been requested, the Medicaid specialist supervisor in the regional office will review the case record, re-examine the action taken on the case, and determine if policy and procedures have been followed. If any adjustments or corrections should be made, the Medicaid specialist supervisor will ensure that corrective action is taken. If the request for hearing was timely made such that continuation of benefits applies, the Medicaid specialist supervisor will ensure that benefits continue at the level before the proposed adverse action that is the subject of the appeal. The Medicaid specialist supervisor will also ensure that all needed information, verification, and evidence is in the case record for the hearing.

(viii) When a state hearing is requested that appeals the action or inaction of a regional office, the regional office will prepare copies of the case record and forward it to the appropriate division in the state office no later than five (5) days after receipt of the request for a state hearing. The original case record will remain in the regional office. Either the original case record in the regional office or the copy forwarded to the state office will be available for inspection by the claimant or claimant's representative a reasonable time before the date of the hearing.

(ix) The Medicaid specialist supervisor will serve as the hearing officer for a local hearing unless the Medicaid specialist supervisor actually participated in the eligibility, benefits, or services decision under appeal, in which case the Medicaid specialist supervisor must appoint a Medicaid specialist in the regional office who did not actually participate in the decision under appeal to serve as hearing officer. The local hearing will be an informal proceeding in which the claimant or representative may present new or additional information, may

question the action taken on the client's case, and will hear an explanation from agency staff as to the regulations and requirements that were applied to claimant's case in making the decision.

(x) After the hearing, the hearing officer will prepare a written summary of the hearing procedure and file it with the case record. The hearing officer will consider the facts presented at the local hearing in reaching a decision. The claimant will be notified of the local hearing decision on the appropriate form that will state clearly the reason for the decision, the policy that governs the decision, the claimant's right to appeal the decision to the state office, and, if the original adverse action is upheld, the new effective date of the reduction or termination of benefits or services if continuation of benefits applied during the hearing process. The new effective date of the reduction or termination of benefits or services must be at the end of the fifteen-day advance notice period from the mailing date of the notice of hearing decision. The notice to claimant will be made part of the case record.

(xi) The claimant has the right to appeal a local hearing decision by requesting a state hearing in writing within fifteen (15) days of the mailing date of the notice of local hearing decision. The state hearing request should be made to the regional office. If benefits have been continued pending the local hearing process, then benefits will continue throughout the fifteen-day advance notice period for an adverse local hearing decision. If a state hearing is timely requested within the fifteen-day period, then benefits will continue pending the state hearing process. State hearings requested after the fifteen-day local hearing advance notice period will not be accepted unless the initial thirty-day period for filing a hearing request has not expired because the local hearing was held early, in which case a state hearing request will be accepted as timely within the number of days remaining of the unexpired initial thirty-day period in

addition to the fifteen-day time period. Continuation of benefits during the state hearing process, however, will only apply if the state hearing request is received within the fifteen-day advance notice period.

(xii) When a request for a state hearing is received in the regional office, the request will be made part of the case record and the regional office will prepare the case record and forward it to the appropriate division in the state office within five (5) days of receipt of the state hearing request. A request for a state hearing received in the state office will be forwarded to the regional office for inclusion in the case record and the regional office will prepare the case record and forward it to the appropriate division in the state office within five (5) days of receipt of the state hearing request.

(xiii) Upon receipt of the hearing record, an impartial hearing officer will be assigned to hear the case either by the Executive Director of the Division of Medicaid or his or her designee. Hearing officers will be individuals with appropriate expertise employed by the division and who have not been involved in any way with the action or decision on appeal in the case. The hearing officer will review the case record and if the review shows that an error was made in the action of the agency or in the interpretation of policy, or that a change of policy has been made, the hearing officer will discuss these matters with the appropriate agency personnel and request that an appropriate adjustment be made. Appropriate agency personnel will discuss the matter with the claimant and if the claimant is agreeable to the adjustment of the claim, then agency personnel will request in writing dismissal of the hearing and the reason therefor, to be placed in the case record. If the hearing is to go forward, it shall be scheduled by the hearing officer in the manner set forth in subparagraph (iii) of this paragraph (e).

(xiv) In conducting the hearing, the state hearing

officer will inform those present of the following:

(A) That the hearing will be recorded on tape and that a transcript of the proceedings will be typed for the record;

(B) The action taken by the agency which prompted the appeal;

(C) An explanation of the claimant's rights during the hearing as outlined in subparagraph (vi) of this paragraph (e);

(D) That the purpose of the hearing is for the claimant to express dissatisfaction and present additional information or evidence;

(E) That the case record is available for review by the claimant or representative during the hearing;

(F) That the final hearing decision will be rendered by the Executive Director of the Division of Medicaid on the basis of facts presented at the hearing and the case record and that the claimant will be notified by letter of the final decision.

(xv) During the hearing, the claimant and/or representative will be allowed an opportunity to make a full statement concerning the appeal and will be assisted, if necessary, in disclosing all information on which the claim is based. All persons representing the claimant and those representing the Division of Medicaid will have the opportunity to state all facts pertinent to the appeal. The hearing officer may recess or continue the hearing for a reasonable time should additional information or facts be required or if some change in the claimant's circumstances occurs during the hearing process which impacts the appeal. When all information has been presented, the hearing officer will close the hearing and stop the recorder.

(xvi) Immediately following the hearing the hearing tape will be transcribed and a copy of the transcription

forwarded to the regional office for filing in the case record. As soon as possible, the hearing officer shall review the evidence and record of the proceedings, testimony, exhibits, and other supporting documents, prepare a written summary of the facts as the hearing officer finds them, and prepare a written recommendation of action to be taken by the agency, citing appropriate policy and regulations that govern the recommendation. The decision cannot be based on any material, oral or written, not available to the claimant before or during the hearing. The hearing officer's recommendation will become part of the case record which will be submitted to the Executive Director of the Division of Medicaid for further review and decision.

(xvii) The Executive Director of the Division of Medicaid, upon review of the recommendation, proceedings and the record, may sustain the recommendation of the hearing officer, reject the same, or remand the matter to the hearing officer to take additional testimony and evidence, in which case, the hearing officer thereafter shall submit to the executive director a new recommendation. The executive director shall prepare a written decision summarizing the facts and identifying policies and regulations that support the decision, which shall be mailed to the claimant and the representative, with a copy to the regional office if appropriate, as soon as possible after submission of a recommendation by the hearing officer. The decision notice will specify any action to be taken by the agency, specify any revised eligibility dates or, if continuation of benefits applies, will notify the claimant of the new effective date of reduction or termination of benefits or services, which will be fifteen (15) days from the mailing date of the notice of decision. The decision rendered by the Executive Director of the Division of Medicaid is final and binding. The claimant is entitled to seek judicial review in a court of proper jurisdiction.

(xviii) The Division of Medicaid must take final administrative action on a hearing, whether state or local, within

ninety (90) days from the date of the initial request for a hearing.

(xix) A group hearing may be held for a number of claimants under the following circumstances:

(A) The Division of Medicaid may consolidate the cases and conduct a single group hearing when the only issue involved is one of a single law or agency policy;

(B) The claimants may request a group hearing when there is one issue of agency policy common to all of them.

In all group hearings, whether initiated by the Division of Medicaid or by the claimants, the policies governing fair hearings must be followed. Each claimant in a group hearing must be permitted to present his or her own case and be represented by his or her own representative, or to withdraw from the group hearing and have his or her appeal heard individually. As in individual hearings, the hearing will be conducted only on the issue being appealed, and each claimant will be expected to keep individual testimony within a reasonable time frame as a matter of consideration to the other claimants involved.

(xx) Any specific matter necessitating an administrative hearing not otherwise provided under this article or agency policy shall be afforded under the hearing procedures as outlined above. If the specific time frames of such a unique matter relating to requesting, granting, and concluding of the hearing is contrary to the time frames as set out in the hearing procedures above, the specific time frames will govern over the time frames as set out within these procedures.

(4) The Executive Director of the Division of Medicaid, with the approval of the Governor, shall be authorized to employ eligibility, technical, clerical and supportive staff as may be required in carrying out and fully implementing the determination of Medicaid eligibility, including conducting quality control reviews and the investigation of the improper receipt of medical assistance. Staffing needs will be set forth in the annual

appropriation act for the division. Additional office space as needed in performing eligibility, quality control and investigative functions shall be obtained by the division.

SECTION 7. Section 43-13-117, Mississippi Code of 1972, is amended as follows:

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

(1) Inpatient hospital services.

(a) The division shall allow thirty (30) days of inpatient hospital care annually for all Medicaid recipients * * *. The division shall be authorized to allow unlimited days in disproportionate hospitals as defined by the division for eligible infants under the age of six (6) years.

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

(2) Outpatient hospital services. <u>The division shall develop a Medicaid-specific cost-to-charge ratio calculation to determine the allowable payment for outpatient hospital services and shall reimburse a hospital the full allowable amount for outpatient services as determined by such calculation.</u> Provided that where the same services are reimbursed as clinic services, the division may revise the rate or methodology of outpatient reimbursement to maintain consistency, efficiency, economy and quality of care.

(3) Laboratory and X-ray services.

(4) Nursing facility services.

(a) The division shall make full payment to nursing facilities for each day, not exceeding fifty-two (52) days per year, that a patient is absent from the facility on home leave. Payment may be made for the following home leave days in addition to the 52-day limitation: Christmas, the day before Christmas, the day after Christmas, Thanksgiving, the day before Thanksgiving and the day after Thanksgiving. However, before payment may be made for more than eighteen (18) home leave days in a year for a patient, the patient must have written authorization from a physician stating that the patient is physically and mentally able to be away from the facility on home leave. Such authorization must be filed with the division before it will be effective and the authorization shall be effective for three (3) months from the date it is received by the division, unless it is revoked earlier by the physician because of a change in the condition of the patient.

(b) From and after July 1, 1997, the division shall implement the integrated case-mix payment and quality monitoring system * * *, which includes the fair rental system for property costs and in which recapture of depreciation is eliminated. The division may reduce the payment * * * for hospital leave and therapeutic home leave days to the lower of the case-mix category as computed for the resident on leave using the assessment being utilized for payment at that point in time, or a case-mix score of 1.000 for nursing facilities, shall compute case-mix scores of residents so that only services provided at the nursing facility are considered in calculating a facility's per diem * * *. * * * The division is authorized to limit allowable management fees and home office costs to either three percent (3%), five percent (5%) or seven percent (7%) of other allowable costs, including allowable therapy costs and property costs, based on the types of management services provided, as follows:

A maximum of up to three percent (3%) shall be allowed where

centralized managerial and administrative services are provided by the management company or home office.

A maximum of up to five percent (5%) shall be allowed where centralized managerial and administrative services and limited professional and consultant services are provided.

A maximum of up to seven percent (7%) shall be allowed where a full spectrum of centralized managerial services, administrative services, professional services and consultant services are provided.

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

(d) The Division of Medicaid shall develop and implement a nursing facility preadmission screening program for Medicaid beneficiaries and applicants. The nursing facility preadmission screening program shall be conducted by a screening team consisting of two (2) members, with a licensed physician available for consultation. Medicaid certified nursing facilities shall provide an individual who applies for admission to the nursing facility or the individual's parent or guardian, if the individual is not competent, a notification in writing on forms prepared by the division of the following:

(i) No Medicaid funds shall be paid for nursing facility care for Medicaid beneficiaries or applicants admitted to nursing facilities on or after July 1, 1999, who have failed to participate in the nursing facility preadmission screening program.

(ii) The nursing facility preadmission screening program consists of an assessment of the applicant's need for care in a nursing facility made by a team of individuals familiar with the needs of individuals seeking admissions to nursing facilities.

Placement in a nursing facility may not be denied by the screening team if any of the following conditions exist:

(i) Community services that would be more

appropriate than care in a nursing facility are not actually available;

(ii) The applicant chooses not to receive the appropriate community service.

An applicant aggrieved by a determination of the screening team may appeal the determination under rules and procedures adopted by the division.

The division shall make full payment for nursing facility preadmission screening team services.

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

The division shall coordinate pre-admission screening to avoid duplication with hospital discharge planning procedures and with screening by local area agencies on aging.

(e) When a facility of a category that does not require a certificate of need for construction and that could not be eligible for Medicaid reimbursement is constructed to nursing facility specifications for licensure and certification, and the facility is subsequently converted to a nursing facility pursuant to a certificate of need that authorizes conversion only and the applicant for the certificate of need was assessed an application review fee based on capital expenditures incurred in constructing the facility, the division shall allow reimbursement for capital expenditures necessary for construction of the facility that were incurred within the twenty-four (24) consecutive calendar months immediately preceding the date that the certificate of need authorizing such conversion was issued, to the same extent that reimbursement would be allowed for construction of a new nursing facility pursuant to a certificate of need that authorizes such construction. The reimbursement authorized in this subparagraph (e) may be made only to facilities the construction of which was completed after June 30, 1989. Before the division shall be

authorized to make the reimbursement authorized in this subparagraph (e), the division first must have received approval from the Health Care Financing Administration of the United States Department of Health and Human Services of the change in the state Medicaid plan providing for such reimbursement.

(f) The division shall develop and implement a case-mix payment add-on determined by time studies and other valid statistical data which will reimburse a nursing facility for the additional cost of caring for a resident who has a diagnosis of Alzheimer's or other related dementia, or exhibits the symptoms thereof. Any such case-mix add-on payment shall be supported by a determination of additional cost. The division shall also develop and implement as part of the fair rental reimbursement system for nursing facility beds, an Alzheimer's resident bed depreciation enhanced reimbursement system which will provide an incentive to encourage nursing facilities to convert or construct beds for residents with Alzheimer's or other related dementia.

(5) Periodic screening and diagnostic services for individuals under age twenty-one (21) years as are needed to identify physical and mental defects and to provide health care treatment and other measures designed to correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services regardless of whether these services are included in the state plan. The division may include in its periodic screening and diagnostic program those discretionary services authorized under the federal regulations adopted to implement Title XIX of the federal Social Security Act, as amended. The division, in obtaining physical therapy services, occupational therapy services, and services for individuals with speech, hearing and language disorders, may enter into a cooperative agreement with the State Department of Education for the provision of such services to handicapped students by public school districts using state funds which are provided from the appropriation to the Department of Education to obtain federal

matching funds through the division. The division, in obtaining medical and psychological evaluations for children in the custody of the State Department of Human Services may enter into a cooperative agreement with the State Department of Human Services for the provision of such services using state funds which are provided from the appropriation to the Department of Human Services to obtain federal matching funds through the division.

On July 1, 1993, all fees for periodic screening and diagnostic services under this paragraph (5) shall be increased by twenty-five percent (25%) of the reimbursement rate in effect on June 30, 1993.

(6) Physician's services. * * * Fees for physicians' services shall be reimbursed at not less than ninety (90%) of the rate established on January 1, 1999, under Medicare (Title XVIII of the Social Security Act), as amended, and which shall, in no event, be less than seventy percent (70%) of the rate as established on January 1, 1994. The division shall pay ten percent (10%) of any co-payment for physician's services rendered to a person dually eligible for Medicaid and Medicare.

(7) (a) Home health services for eligible persons, not to exceed in cost the prevailing cost of nursing facility services, not to exceed sixty (60) visits per year. The Division of Medicaid may require home health service providers to obtain a surety bond in the amount and to the specifications as established under the Balanced Budget Act 1997.

(b) The division may revise reimbursement for home health services in order to establish equity between reimbursement for home health services and reimbursement for institutional services within the Medicaid program. This paragraph (b) shall stand repealed on July 1, 1997.

(8) Emergency medical transportation services. On January 1, 1994, emergency medical transportation services shall be reimbursed at seventy percent (70%) of the rate established under Medicare (Title XVIII of the Social Security Act), as amended.

"Emergency medical transportation services" shall mean, but shall not be limited to, the following services by a properly permitted ambulance operated by a properly licensed provider in accordance with the Emergency Medical Services Act of 1974 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids, (vi) disposable supplies, (vii) similar services.

(9) Legend and other drugs as may be determined by the division. The division may implement a program of prior approval for drugs to the extent permitted by law. Payment by the division for covered multiple source drugs shall be limited to the lower of the upper limits established and published by the Health Care Financing Administration (HCFA) plus a dispensing fee of Four Dollars and Ninety-one Cents ($4.91), or the estimated acquisition cost (EAC) as determined by the division plus a dispensing fee of Four Dollars and Ninety-one Cents ($4.91), or the providers' usual and customary charge to the general public. The division shall allow five (5) prescriptions per month for noninstitutionalized Medicaid recipients.

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

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

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

As used in this paragraph (9), "estimated acquisition cost"

means the division's best estimate of what price providers generally are paying for a drug in the package size that providers buy most frequently. Product selection shall be made in compliance with existing state law; however, the division may reimburse as if the prescription had been filled under the generic name. The division may provide otherwise in the case of specified drugs when the consensus of competent medical advice is that trademarked drugs are substantially more effective.

(10) Dental care that is an adjunct to treatment of an acute medical or surgical condition; services of oral surgeons and dentists in connection with surgery related to the jaw or any structure contiguous to the jaw or the reduction of any fracture of the jaw or any facial bone; and emergency dental extractions and treatment related thereto. On July 1, 1999, all fees for dental care and surgery under authority of this paragraph (10) shall be increased to twice the amount of the reimbursement rate * * * in effect on June 30, 1999.

(11) Eyeglasses necessitated by reason of eye surgery, and as prescribed by a physician skilled in diseases of the eye or an optometrist, whichever the patient may select, or one (1) pair every five (5) years as prescribed by a physician or an optometrist, whichever the patient may select.

(12) Intermediate care facility services.

(a) The division shall make full payment to all intermediate care facilities for the mentally retarded for each day, not exceeding eighty-four (84) days per year, that a patient is absent from the facility on home leave. Payment may be made for the following home leave days in addition to the 84-day limitation: Christmas, the day before Christmas, the day after Christmas, Thanksgiving, the day before Thanksgiving and the day after Thanksgiving. However, before payment may be made for more than eighteen (18) home leave days in a year for a patient, the patient must have written authorization from a physician stating that the patient is physically and mentally able to be away from

the facility on home leave. Such authorization must be filed with the division before it will be effective, and the authorization shall be effective for three (3) months from the date it is received by the division, unless it is revoked earlier by the physician because of a change in the condition of the patient.

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

(c) The division is authorized to limit allowable management fees and home office costs to either three percent (3%), five percent (5%) or seven percent (7%) of other allowable costs, including allowable therapy costs and property costs, based on the types of management services provided, as follows:

A maximum of up to three percent (3%) shall be allowed where centralized managerial and administrative services are provided by the management company or home office.

A maximum of up to five percent (5%) shall be allowed where centralized managerial and administrative services and limited professional and consultant services are provided.

A maximum of up to seven percent (7%) shall be allowed where a full spectrum of centralized managerial services, administrative services, professional services and consultant services are provided.

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

(14) Clinic services. Such diagnostic, preventive, therapeutic, rehabilitative or palliative services furnished to an outpatient by or under the supervision of a physician or dentist in a facility which is not a part of a hospital but which is organized and operated to provide medical care to outpatients. Clinic services shall include any services reimbursed as outpatient hospital services which may be rendered in such a facility, including those that become so after July 1, 1991. * * *

(15) Home- and community-based services, as provided under Title XIX of the federal Social Security Act, as amended, under waivers, subject to the availability of funds specifically appropriated therefor by the Legislature. Payment for such services shall be limited to individuals who would be eligible for and would otherwise require the level of care provided in a nursing facility. The home- and community-based services authorized under this paragraph shall be expanded to four thousand four hundred (4,400) recipients over a five-year period beginning July 1, 1999. The division shall certify case management agencies to provide case management services and provide for home- and community-based services for eligible individuals under this paragraph. The home- and community-based services under this paragraph and the activities performed by certified case management agencies under this paragraph shall be funded using state funds that are provided from the appropriation to the Division of Medicaid and used to match federal funds * * *.

(16) Mental health services. Approved therapeutic and case management services provided by (a) an approved regional mental health/retardation center established under Sections 41-19-31 through 41-19-39, or by another community mental health service provider meeting the requirements of the Department of Mental Health to be an approved mental health/retardation center if determined necessary by the Department of Mental Health, using state funds which are provided from the appropriation to the State Department of Mental Health and used to match federal funds under a cooperative agreement between the division and the department, or (b) a facility which is certified by the State Department of Mental Health to provide therapeutic and case management services, to be reimbursed on a fee for service basis. Any such services provided by a facility described in paragraph (b) must have the prior approval of the division to be reimbursable under this section. After June 30, 1997, mental health services provided by regional mental health/retardation centers established under

Sections 41-19-31 through 41-19-39, or by hospitals as defined in Section 41-9-3(a) and/or their subsidiaries and divisions, or by psychiatric residential treatment facilities as defined in Section 43-11-1, or by another community mental health service provider meeting the requirements of the Department of Mental Health to be an approved mental health/retardation center if determined necessary by the Department of Mental Health, shall not be included in or provided under any capitated managed care pilot program provided for under paragraph (24) of this section.

(17) Durable medical equipment services and medical supplies * * *. The Division of Medicaid may require durable medical equipment providers to obtain a surety bond in the amount and to the specifications as established by the Balanced Budget Act of 1997.

(18) Notwithstanding any other provision of this section to the contrary, the division shall make additional reimbursement to hospitals which serve a disproportionate share of low-income patients and which meet the federal requirements for such payments as provided in Section 1923 of the federal Social Security Act and any applicable regulations.

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

(b) Early intervention system services. The division shall cooperate with the State Department of Health, acting as lead agency, in the development and implementation of a statewide system of delivery of early intervention services, pursuant to

Part H of the Individuals with Disabilities Education Act (IDEA).

The State Department of Health shall certify annually in writing to the director of the division the dollar amount of state early intervention funds available which shall be utilized as a certified match for Medicaid matching funds. Those funds then shall be used to provide expanded targeted case management services for Medicaid eligible children with special needs who are eligible for the state's early intervention system. Qualifications for persons providing service coordination shall be determined by the State Department of Health and the Division of Medicaid.

(20) Home- and community-based services for physically disabled approved services as allowed by a waiver from the U.S. Department of Health and Human Services for home- and community-based services for physically disabled people using state funds which are provided from the appropriation to the State Department of Rehabilitation Services and used to match federal funds under a cooperative agreement between the division and the department, provided that funds for these services are specifically appropriated to the Department of Rehabilitation Services.

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

(22) Ambulatory services delivered in federally qualified health centers and in clinics of the local health departments of the State Department of Health for individuals eligible for

medical assistance under this article based on reasonable costs as determined by the division.

(23) Inpatient psychiatric services. Inpatient psychiatric services to be determined by the division for recipients under age twenty-one (21) which are provided under the direction of a physician in an inpatient program in a licensed acute care psychiatric facility or in a licensed psychiatric residential treatment facility, before the recipient reaches age twenty-one (21) or, if the recipient was receiving the services immediately before he reached age twenty-one (21), before the earlier of the date he no longer requires the services or the date he reaches age twenty-two (22), as provided by federal regulations. Recipients shall be allowed forty-five (45) days per year of psychiatric services provided in acute care psychiatric facilities, and shall be allowed unlimited days of psychiatric services provided in licensed psychiatric residential treatment facilities. The division is authorized to limit allowable management fees and home office costs to either three percent (3%), five percent (5%) or seven percent (7%) of other allowable costs, including allowable therapy costs and property costs, based on the types of management services provided, as follows:

A maximum of up to three percent (3%) shall be allowed where centralized managerial and administrative services are provided by the management company or home office.

A maximum of up to five percent (5%) shall be allowed where centralized managerial and administrative services and limited professional and consultant services are provided.

A maximum of up to seven percent (7%) shall be allowed where a full spectrum of centralized managerial services, administrative services, professional services and consultant services are provided.

(24) Managed care services in a program to be developed by the division by a public or private provider. Notwithstanding any other provision in this article to the contrary, the division

shall establish rates of reimbursement to providers rendering care and services authorized under this section, and may revise such rates of reimbursement without amendment to this section by the Legislature for the purpose of achieving effective and accessible health services, and for responsible containment of costs. * * *

Beginning July 1, 1999, the division may require enrollment in any county where this program is implemented.

From and after passage of this act, Medicaid eligibility is guaranteed up to six (6) months for individuals enrolled in a Medicaid managed care program.

A Medicaid Managed Care Marketing Advisory Committee is established within the Division of Medicaid, with membership and responsibilities to be prescribed by the Balanced Budget Act of 1997, and per diem compensation as authorized by law.

(25) Birthing center services.

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

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

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

(29) The Division of Medicaid may apply for a waiver from

the Department of Health and Human Services for home- and community-based services for developmentally disabled people using state funds which are provided from the appropriation to the State Department of Mental Health and used to match federal funds under a cooperative agreement between the division and the department, provided that funds for these services are specifically appropriated to the Department of Mental Health.

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

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

(32) Care and services provided in Christian Science Sanatoria operated by or listed and certified by The First Church of Christ Scientist, Boston, Massachusetts, rendered in connection with treatment by prayer or spiritual means to the extent that such services are subject to reimbursement under Section 1903 of the Social Security Act.

(33) Podiatrist services.

(34) * * *

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

(36) Nonemergency transportation services for Medicaid-eligible persons, to be provided by the Division of Medicaid. The division may contract with additional entities to administer non-emergency transportation services as it deems necessary. All providers shall have a valid driver's license, vehicle inspection sticker, valid vehicle license tags and a

standard liability insurance policy covering the vehicle.

(37) Targeted case management services for individuals with chronic diseases, with expanded eligibility to cover services to uninsured recipients, on a pilot program basis. This paragraph (37) shall be contingent upon continued receipt of special funds from the Health Care Financing Authority and private foundations who have granted funds for planning these services. No funding for these services shall be provided from State General Funds.

(38) Chiropractic services: a chiropractor's manual manipulation of the spine to correct a subluxation, if x-ray demonstrates that a subluxation exists and if the subluxation has resulted in a neuromusculoskeletal condition for which manipulation is appropriate treatment. Reimbursement for chiropractic services shall not exceed Seven Hundred Dollars ($700.00) per year per recipient.

(39) Qualified Medicare Beneficiaries. The division shall pay Medicare cost-sharing for qualified Medicare beneficiaries in amounts based on the full Medicare-approved amount for coinsurance, deductibles and copayments for qualified Medicare beneficiaries for inpatient hospital services and long-term care facilities.

(40) The division shall prepare an application for a waiver to provide prescription drug benefits to as many Mississippians as permitted under Title XIX of the Social Security Act.

Notwithstanding any provision of this article, except as authorized in the following paragraph and in Section 43-13-139, neither (a) the limitations on quantity or frequency of use of or the fees or charges for any of the care or services available to recipients under this section, nor (b) the payments or rates of reimbursement to providers rendering care or services authorized under this section to recipients, may be increased, decreased or otherwise changed from the levels in effect on July 1, 1999, unless such is authorized by an amendment to this section by the Legislature. However, the restriction in this paragraph shall not

prevent the division from changing the payments or rates of reimbursement to providers without an amendment to this section whenever such changes are required by federal law or regulation, or whenever such changes are necessary to correct administrative errors or omissions in calculating such payments or rates of reimbursement.

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

SECTION 8. Section 43-13-121, Mississippi Code of 1972, is amended as follows:

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

(a) Adopt and promulgate reasonable rules, regulations and standards, with approval of the Governor<u>, and in accordance</u>

with the Administrative Procedures Act, Section 25-43-1 et seq.:

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

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

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

(iv) Providing for fair and impartial hearings;

(v) Providing safeguards for preserving the confidentiality of records; and

(vi) For detecting and processing fraudulent practices and abuses of the program;

(b) Receive and expend state, federal and other funds in accordance with court judgments or settlements and agreements between the State of Mississippi and the federal government, the rules and regulations promulgated by the division, with the approval of the Governor, and within the limitations and restrictions of this article and within the limits of funds available for such purpose;

(c) Subject to the limits imposed by this article, to submit a plan for medical assistance to the federal Department of Health and Human Services for approval pursuant to the provisions of the Social Security Act, to act for the state in making negotiations relative to the submission and approval of such plan, to make such arrangements, not inconsistent with the law, as may be required by or pursuant to federal law to obtain and retain such approval and to secure for the state the benefits of the provisions of such law;

No agreements, specifically including the general plan for the operation of the Medicaid program in this state, shall be made by and between the division and the Department of Health and Human Services unless the Attorney General of the State of Mississippi has reviewed said agreements, specifically including said operational plan, and has certified in writing to the Governor and to the director of the division that said agreements, including said plan of operation, have been drawn strictly in accordance with the terms and requirements of this article;

(d) Pursuant to the purposes and intent of this article and in compliance with its provisions, provide for aged persons otherwise eligible for the benefits provided under Title XVIII of the federal Social Security Act by expenditure of funds available for such purposes;

(e) To make reports to the federal Department of Health and Human Services as from time to time may be required by such federal department and to the Mississippi Legislature as hereinafter provided;

(f) Define and determine the scope, duration and amount of medical assistance which may be provided in accordance with this article and establish priorities therefor in conformity with this article;

(g) Cooperate and contract with other state agencies for the purpose of coordinating medical assistance rendered under this article and eliminating duplication and inefficiency in the program;

(h) Adopt and use an official seal of the division;

(i) Sue in its own name on behalf of the State of Mississippi and employ legal counsel on a contingency basis with the approval of the Attorney General;

(j) To recover any and all payments incorrectly made by the division or by the Medicaid Commission to a recipient or provider from the recipient or provider receiving said payments;

(k) To recover any and all payments by the division or

by the Medicaid Commission fraudulently obtained by a recipient or provider. Additionally, if recovery of any payments fraudulently obtained by a recipient or provider is made in any court, then, upon motion of the Governor, the judge of said court may award twice the payments recovered as damages;

(l) Have full, complete and plenary power and authority to conduct such investigations as it may deem necessary and requisite of alleged or suspected violations or abuses of the provisions of this article or of the regulations adopted hereunder including, but not limited to, fraudulent or unlawful act or deed by applicants for medical assistance or other benefits, or payments made to any person, firm or corporation under the terms, conditions and authority of this article, to suspend or disqualify any provider of services, applicant or recipient for gross abuse, fraudulent or unlawful acts for such periods, including permanently, and under such conditions as the division may deem proper and just, including the imposition of a legal rate of interest on the amount improperly or incorrectly paid. Should an administrative hearing become necessary, the division shall be authorized, should the provider not succeed in his defense, in taxing the costs of the administrative hearing, including the costs of the court reporter or stenographer and transcript, to the provider. The convictions of a recipient or a provider in a state or federal court for abuse, fraudulent or unlawful acts under this chapter shall constitute an automatic disqualification of the recipient or automatic disqualification of the provider from participation under the Medicaid program.

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

(m) Establish and provide such methods of administration as may be necessary for the proper and efficient operation of the program, fully utilizing computer equipment as may be necessary to oversee and control all current expenditures for purposes of this article, and to closely monitor and supervise all recipient payments and vendors rendering such services hereunder; and

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

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

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

(4) The division and its hearing officers shall have power to preserve and enforce order during hearings; to issue subpoenas for, to administer oaths to and to compel the attendance and testimony of witnesses, or the production of books, papers, documents and other evidence, or the taking of depositions before any designated individual competent to administer oaths; to

examine witnesses; and to do all things conformable to law which may be necessary to enable them effectively to discharge the duties of their office. In compelling the attendance and testimony of witnesses, or the production of books, papers, documents and other evidence, or the taking of depositions, as authorized by this section, the division or its hearing officers may designate an individual employed by the division or some other suitable person to execute and return such process, whose action in executing and returning such process shall be as lawful as if done by the sheriff or some other proper officer authorized to execute and return process in the county where the witness may reside. In carrying out the investigatory powers under the provisions of this article, the director or other designated person or persons shall be authorized to examine, obtain, copy or reproduce the books, papers, documents, medical charts, prescriptions and other records relating to medical care and services furnished by said provider to a recipient or designated recipients of Medicaid services under investigation. In the absence of the voluntary submission of said books, papers, documents, medical charts, prescriptions and other records, the Governor, the director, or other designated person shall be authorized to issue and serve subpoenas instantly upon such provider, his agent, servant or employee for the production of said books, papers, documents, medical charts, prescriptions or other records during an audit or investigation of said provider. If any provider or his agent, servant or employee should refuse to produce said records after being duly subpoenaed, the director shall be authorized to certify such facts and institute contempt proceedings in the manner, time, and place as authorized by law for administrative proceedings. As an additional remedy, the division shall be authorized to recover all amounts paid to said provider covering the period of the audit or investigation, inclusive of a legal rate of interest and a reasonable attorney's fee and costs of court if suit becomes necessary. Division staff

shall have immediate access to the provider's physical location, facilities, records, documents, books, and any other records relating to medical care and services rendered to recipients during regular business hours and all other hours when employees of the provider are available and conducting the business of the provider.

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

(6) In suspending or terminating any provider from participation in the Medicaid program, the division shall preclude such provider from submitting claims for payment, either personally or through any clinic, group, corporation or other association to the division or its fiscal agents for any services or supplies provided under the Medicaid program except for those services or supplies provided prior to the suspension or termination. No clinic, group, corporation or other association which is a provider of services shall submit claims for payment to the division or its fiscal agents for any services or supplies provided by a person within such organization who has been suspended or terminated from participation in the Medicaid program

except for those services or supplies provided prior to the suspension or termination. When said provision is violated by a provider of services which is a clinic, group, corporation or other association, the division may suspend or terminate such organization from participation. Suspension may be applied by the division to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case by case basis after giving due regard to all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the provider is affiliated where such conduct was accomplished with the course of his official duty or was effectuated by him with the knowledge or approval of such person.

(7) If the division ascertains that a provider has been convicted of a felony under federal or state law for an offense which the division determines is detrimental to the best interests of the program or of Medicaid recipients, the division may refuse to enter into an agreement with such provider, or may terminate or refuse to renew an existing agreement.

SECTION 9. Section 43-13-122, Mississippi Code of 1972, is amended as follows:

43-13-122. (1) The division is authorized to apply to the Health Care Financing Administration of the U.S. Department of Health and Human Services for waivers and research and demonstration grants as are otherwise authorized by the Legislature in this chapter.

* * *

(2) The division is further authorized to accept and expend any grants, donations or contributions from any public or private organization together with any additional federal matching funds that may accrue and including, but not limited to, one hundred percent (100%) federal grant funds or funds from any governmental entity or instrumentality thereof in furthering the purposes and objectives of the Mississippi Medicaid program, provided that such

receipts and expenditures are reported and otherwise handled in accordance with the General Fund Stabilization Act. The Department of Finance and Administration is authorized to transfer monies to the division from special funds in the State Treasury in amounts not exceeding the amounts authorized in the appropriation to the division.

SECTION 10. Section 43-13-125, Mississippi Code of 1972, is amended as follows:

43-13-125. (1) If medical assistance is provided to a recipient under this article for injuries, disease or sickness caused under circumstances creating a cause of action in favor of the recipient against any person, firm or corporation, then the division shall be entitled to recover the proceeds that may result from the exercise of any rights of recovery which the recipient may have against any such person, firm or corporation to the extent of the * * * Division of Medicaid's interest on behalf of the recipient. The recipient shall execute and deliver instruments and papers to do whatever is necessary to secure such rights and shall do nothing after said medical assistance is provided to prejudice the subrogation rights of the division. Court orders or agreements for reimbursement of Medicaid's interest shall direct such payments to the Division of Medicaid, which shall be authorized to endorse any and all * * *, including, but not limited to, multi-payee checks, drafts, money orders, or other negotiable instruments representing Medicaid payment recoveries that are received. In accordance with Section 43-13-305, Mississippi Code of 1972, endorsement of multi-payee checks, drafts, money orders or other negotiable instruments by the Division of Medicaid shall be deemed endorsed by the recipient.

The division, with the approval of the Governor, may compromise or settle any such claim and execute a release of any claim it has by virtue of this section.

(2) The acceptance of medical assistance under this article

or the making of a claim thereunder shall not affect the right of a recipient or his legal representative to recover Medicaid's interest as an element of special damages in any action at law; provided, however, that a copy of the pleadings shall be certified to the division at the time of the institution of suit, and proof of such notice shall be filed of record in such action. The division may, at any time before the trial on the facts, join in such action or may intervene therein. Any amount recovered by a recipient or his legal representative shall be applied as follows:

(a) The reasonable costs of the collection, including attorney's fees, as approved and allowed by the court in which such action is pending, or in case of settlement without suit, by the legal representative of the division;

(b) The * * * amount of Medicaid's interest on behalf of the recipient; or such pro rata amount as may be arrived at by the legal representative of the division and the recipient's attorney, or as set by the court having jurisdiction; and

(c) Any excess shall be awarded to the recipient.

(3) No compromise of any claim by the recipient or his legal representative shall be binding upon or affect the rights of the division against the third party unless the division, with the approval of the Governor, has entered into the compromise. Any compromise effected by the recipient or his legal representative with the third party in the absence of advance notification to and approved by the division shall constitute conclusive evidence of the liability of the third party, and the division, in litigating its claim against said third party, shall be required only to prove the amount and correctness of its claim relating to such injury, disease or sickness. It is further provided that should the recipient or his legal representative fail to notify the division of the institution of legal proceedings against a third party for which the division has a cause of action, the facts relating to negligence and the liability of the third party, if judgment is rendered for the recipient, shall constitute

conclusive evidence of liability in a subsequent action maintained by the division and only the amount and correctness of the division's claim relating to injuries, disease or sickness shall be tried before the court. The division shall be authorized in bringing such action against the third party and his insurer jointly or against the insurer alone.

(4) Nothing herein shall be construed to diminish or otherwise restrict the subrogation rights of the Division of Medicaid against a third party for medical assistance provided by the Division of Medicaid * * * to the recipient as a result of injuries, disease or sickness caused under circumstances creating a cause of action in favor of the recipient against such a third party.

(5) Any amounts recovered by the division under this section shall, by the division, be placed to the credit of the funds appropriated for benefits under this article proportionate to the amounts provided by the state and federal governments respectively.

SECTION 11. Section 43-13-137, Mississippi Code of 1972, is amended as follows:

43-13-137. The division is an agency as defined under Section 25-43-3 and, therefore, must comply in all respects with the Administrative Procedures Act, Section 25-43-1 et seq. This requirement to comply with the Administrative Procedures Act applies to any and all amendments, modifications and changes to the plan for the operation of the Medicaid program in this state and any and all procedural rules, regulations and policies and any and all changes or amendments thereto.

SECTION 12. Section 43-13-305, Mississippi Code of 1972, is amended as follows:

43-13-305. (1) By accepting Medicaid from the Division of Medicaid in the Office of the Governor, the recipient shall, to the extent of the payment of medical expenses by the Division of Medicaid, be deemed to have made an assignment to the Division of

Medicaid of any and all rights and interests in any third-party benefits, hospitalization or indemnity contract or any cause of action, past, present or future, against any person, firm or corporation for Medicaid benefits provided to the recipient by the Division of Medicaid for injuries, disease or sickness caused or suffered under circumstances creating a cause of action in favor of the recipient against any such person, firm or corporation as set out in Section 43-13-125. The recipient shall be deemed, without the necessity of signing any document, to have appointed the Division of Medicaid as his or her true and lawful attorney-in-fact in his or her name, place and stead in collecting any and all amounts due and owing for medical expenses paid by the Division of Medicaid against such person, firm or corporation.

(2) Whenever a provider of medical services or the Division of Medicaid submits claims to an insurer on behalf of a Medicaid recipient for whom an assignment of rights has been received, or whose rights have been assigned by the operation of law, the insurer must respond within sixty (60) days of receipt of a claim by forwarding payment or issuing a notice of denial directly to the submitter of the claim. The failure of the insuring entity to comply with the provisions of this section shall subject the insuring entity to recourse by the Division of Medicaid in accordance with the provision of Section 43-13-315. <u>The Division of Medicaid shall be authorized to endorse any and all, including, but not limited to, multi-payee checks, drafts, money orders or other negotiable instruments representing Medicaid payment recoveries that are received by the Division of Medicaid.</u>

(3) Court orders or agreements for medical support shall direct such payments to the Division of Medicaid, which shall be authorized to endorse any and all checks, drafts, money orders or other negotiable instruments representing medical support payments which are received. Any designated medical support funds received by the State Department of Human Services or through its local county departments shall be paid over to the Division of Medicaid.

When medical support for a Medicaid recipient is available through an absent parent or custodial parent, the insuring entity shall direct the medical support payment(s) to the provider of medical services or to the Division of Medicaid.

SECTION 13. This act shall take effect and be in force from and after its passage.