MISSISSIPPI LEGISLATURE REGULAR SESSION 1999

By: Senator(s) Bean To: Public Health and Welfare

SENATE BILL NO. 2143

1 AN ACT RELATING TO MEDICAID ASSISTANCE; TO AMEND SECTIONS
2 43-13-103 AND 43-13-105, MISSISSIPPI CODE OF 1972, TO AUTHORIZE
3 THE DIVISION OF MEDICAID TO EXPEND FUNDS UNDER TITLE XXI OF THE
4 FEDERAL SOCIAL SECURITY ACT; TO AMEND SECTION 43-13-111,
5 MISSISSIPPI CODE OF 1972, TO CLARIFY THAT EACH STATE AGENCY SHALL
6 REQUEST AND OBTAIN AN APPROPRIATION FOR ALL MEDICAID PROGRAMS
7 ADMINISTERED BY SUCH AGENCY; TO AMEND SECTION 43-13-113,
8 MISSISSIPPI CODE OF 1972, TO DELETE THE AUTHORITY FOR THE DIVISION
9 OF MEDICAID TO CONTRACT FOR DONATED DENTAL SERVICES; TO AMEND
10 SECTION 43-13-115, MISSISSIPPI CODE OF 1972, TO DEFINE THOSE
11 INDIVIDUALS ELIGIBLE FOR MEDICAID ASSISTANCE; TO AMEND SECTION
12 43-13-116, MISSISSIPPI CODE OF 1972, TO PROVIDE FOR LOCAL AND
13 STATE HEARING REQUESTS BY CLAIMANTS; TO AMEND SECTION 43-13-117,
14 MISSISSIPPI CODE OF 1972, TO DELETE THE REQUIREMENT FOR DIVISION
15 OF MEDICAID APPROVAL FOR REIMBURSEMENT FOR MORE THAN 15 DAYS OF
16 INPATIENT HOSPITAL CARE, TO PROVIDE THAT THE MEDICAID RATES FOR
17 OUT-OF-STATE HOSPITALS MAY BE REVISED CONSISTENT WITH FEDERAL LAW,
18 TO AUTHORIZE THE DIVISION TO EVALUATE AND IMPLEMENT CONVERSION TO
19 MEDICARE REIMBURSEMENT METHODOLOGIES FOR INPATIENT AND OUTPATIENT
20 SERVICES, TO ELIMINATE GRADUATE MEDICAL EDUCATION IN CALCULATION
21 OF HOSPITAL MEDICAID RATES, TO INCREASE THE AUTHORIZED NUMBER OF
22 HOME LEAVE DAYS FOR NURSING FACILITY SERVICES AND ICFMR SERVICES
23 REIMBURSEMENT, TO DELETE THE REPEALER ON THE CASE-MIX
24 REIMBURSEMENT SYSTEM FOR NURSING FACILITY SERVICES, TO AUTHORIZE
25 THE DIVISION TO REDUCE THE PAYMENT FOR HOSPITAL LEAVE AND HOME
26 LEAVE FOR A NURSING FACILITY RESIDENT USING CERTAIN CASE-MIX
27 CRITERIA AND TO AUTHORIZE THE DIVISION TO LIMIT CERTAIN MANAGEMENT
28 FEES AND HOME OFFICE COSTS FOR NURSING FACILITIES, ICFMR'S AND
29 PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES, TO DELETE CERTAIN
30 REQUIREMENTS FOR REIMBURSEMENT TO NURSING FACILITIES FOR RETURN ON
31 EQUITY CAPITAL, TO REQUIRE ALL STATE-OWNED NURSING FACILITIES TO
32 BE REIMBURSED ON A FULL COST BASIS AFTER A CERTAIN DATE, TO DELETE
33 THE PROVISION ESTABLISHING AND EMPOWERING THE MEDICAID REVIEW
34 BOARD FOR NURSING FACILITIES, TO REQUIRE A NURSING FACILITY
35 PREADMISSION SCREENING PROGRAM FOR MEDICAID BENEFICIARIES AND
36 APPLICANTS, TO PROVIDE FOR A PREADMISSION SCREENING TEAM, TO
37 PROVIDE MEDICAID REIMBURSEMENT FOR PREADMISSION SCREENING SERVICES
38 AND TO DELETE THE REQUIREMENT THAT THE DIVISION OF MEDICAID
39 PROVIDE HOME- AND COMMUNITY-BASED SERVICES UNDER A COOPERATIVE
40 AGREEMENT WITH THE DEPARTMENT OF HUMAN SERVICES, TO PROVIDE FOR A
41 NURSING FACILITY WAITING LIST AND TO PROHIBIT THE REQUIREMENT OF
42 NOTICE BEFORE DISCHARGED, TO DIRECT THE DIVISION TO DEVELOP AND
43 IMPLEMENT A PLAN TO INCREASE PARTICIPATION IN THE EPSDT PROGRAM,
44 TO INCREASE THE PHYSICIAN'S FEE REIMBURSEMENT UNDER MEDICAID AND
45 TO DIRECT THE DIVISION TO DEVELOP A SCHEDULE OF PHYSICIANS
46 SERVICES REIMBURSEMENT WHICH IS RELATIVE TO PAYMENTS UNDER
47 MEDICARE, TO AUTHORIZE THE DIVISION TO REQUIRE HOME HEALTH
48 SERVICES PROVIDERS TO OBTAIN A SURETY BOND, TO DELETE THE REPEALER
49 ON THE PROVISION REQUIRING EQUITY BETWEEN REIMBURSEMENT FOR HOME
50 HEALTH SERVICES AND INSTITUTIONAL SERVICES, TO AUTHORIZE THE
51 DIVISION TO REQUIRE DURABLE MEDICAL EQUIPMENT PROVIDERS TO OBTAIN
52 A SURETY BOND AND TO DELETE THE LIMITATION ON DURABLE MEDICAL

53 EQUIPMENT REIMBURSEMENT, TO DELETE THE REQUIREMENT THAT
54 STATE-OWNED ICFMR FACILITIES ARE REIMBURSED ON A FULL COST BASIS,
55 TO GUARANTEE MEDICAID ELIGIBILITY UP TO SIX MONTHS FOR INDIVIDUALS
56 ENROLLED IN A MEDICAID MANAGED CARE PROGRAM, TO PROVIDE THAT ANY
57 MEDICAID RECIPIENT WHO ENROLLS IN THIS PILOT PROGRAM MUST REMAIN
58 IN THE PILOT PROGRAM FOR NOT LESS THAN ONE YEAR BEFORE THE
59 RECIPIENT WILL BE ALLOWED TO DISENROLL, TO ESTABLISH A MANAGED
60 CARE MARKETING ADVISORY COMMITTEE TO AUTHORIZE MEDICAID
61 REIMBURSEMENT FOR ONE PAIR OF EYEGLASSES EVERY FIVE YEARS, TO
62 DELETE THE AUTHORITY FOR THE PERSONAL CARE SERVICES PILOT PROGRAM,
63 TO DELETE THE REPEALER ON THE PROVISION FOR CHIROPRACTIC SERVICES
64 REIMBURSEMENT, TO AUTHORIZE THE DIVISION TO APPLY FOR WAIVERS FOR
65 CERTAIN COST-EFFECTIVENESS DEMONSTRATION PROJECTS, AND TO CHANGE
66 THE DATE FOR CHANGES IN REIMBURSEMENT RATES REQUIRING LEGISLATIVE
67 APPROVAL; TO AMEND SECTION 43-13-121, MISSISSIPPI CODE OF 1972, TO
68 PROVIDE FOR ACCESS TO PROVIDER RECORDS FOR DIVISION STAFF AND TO
69 DISQUALIFY CERTAIN PROVIDERS FOR REIMBURSEMENT; TO AMEND SECTION
70 43-13-122, MISSISSIPPI CODE OF 1972, IN CONFORMITY THERETO; TO
71 AMEND SECTION 43-13-125, MISSISSIPPI CODE OF 1972, TO CLARIFY THAT
72 THE DIVISION OF MEDICAID'S SUBROGATION RIGHTS ARE TO THE EXTENT OF
73 BENEFITS PROVIDED BY MEDICAID ON BEHALF OF THE RECIPIENT TO WHOM
74 THIRD PARTY PAYMENTS ARE PAYABLE; TO AMEND SECTION 43-13-305,
75 MISSISSIPPI CODE OF 1972, TO AUTHORIZE THE DIVISION OF MEDICAID TO
76 ENDORSE MULTI-PAYEE CHECKS; AND FOR RELATED PURPOSES.

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

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

80 43-13-103. For the purpose of affording health care and
81 remedial and institutional services in accordance with the
82 requirements for federal grants and other assistance under Titles
83 XVIII, XIX and XXI of the Social Security Act, as amended, a
84 statewide system of medical assistance is hereby established and
85 shall be in effect in all political subdivisions of the state, to
86 be financed by state appropriations and federal matching funds
87 therefor, and to be administered by the Office of the Governor as
88 hereinafter provided.

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

91 43-13-105. When used in this article, the following
92 definitions shall apply, unless the context requires otherwise:

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

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

97 (c) "Medical assistance" means payment of part or all

98 of the costs of medical and remedial care provided under the terms
99 of this article and in accordance with provisions of Titles XIX
100 and XXI of the Social Security Act, as amended.
101 (d) "Applicant" means a person who applies for
102 assistance under Titles IV, XVI, XIX or XXI of the Social Security
103 Act, as amended, and under the terms of this article.
104 (e) "Recipient" means a person who is eligible for
105 assistance under Title XIX or XXI of the Social Security Act, as
106 amended and under the terms of this article.
107 (f) "State health agency" shall mean any agency,
108 department, institution, board or commission of the State of
109 Mississippi, except the University Medical School, which is
110 supported in whole or in part by any public funds, including funds
111 directly appropriated from the State Treasury, funds derived by
112 taxes, fees levied or collected by statutory authority, or any
113 other funds used by "state health agencies" derived from federal
114 sources, when any funds available to such agency are expended
115 either directly or indirectly in connection with, or in support
116 of, any public health, hospital, hospitalization or other public
117 programs for the preventive treatment or actual medical treatment
118 of persons who are physically or mentally ill or mentally
119 retarded.
120 (g) "Mississippi Medicaid Commission" or "Medicaid
121 Commission" wherever they appear in the laws of the State of
122 Mississippi, shall mean the Division of Medicaid in the Office of
123 the Governor.
124 SECTION 3. Section 43-13-111, Mississippi Code of 1972, is
125 amended as follows:
126 43-13-111. Every state health agency, as defined in Section
127 43-13-105, shall obtain an appropriation of state funds from the
128 state Legislature for all medical assistance programs rendered by
129 the agency and shall organize its programs and budgets in such a
130 manner as to secure maximum federal funding through the Division
131 of Medicaid under Title XIX or Title XXI of the federal Social

132 Security Act, as amended.

133 SECTION 4. Section 43-13-113, Mississippi Code of 1972, is
134 amended as follows:

135 43-13-113. (1) The State Treasurer is hereby authorized and
136 directed to receive on behalf of the state, and to execute all
137 instruments incidental thereto, federal and other funds to be used
138 for financing the medical assistance plan or program adopted
139 pursuant to this article, and to place all such funds in a special
140 account to the credit of the Governor's Office-Division of
141 Medicaid, which said funds shall be expended by the division for
142 the purposes and under the provisions of this article, and shall
143 be paid out by the State Treasurer as funds appropriated to carry
144 out the provisions of this article are paid out by him.

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

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

165 (a) All providers must submit all claims to the

166 Division of Medicaid's fiscal agent no later than twelve (12)
167 months from the date of service.
168 (b) The Division of Medicaid's fiscal agent must pay
169 ninety percent (90%) of all clean claims within thirty (30) days
170 of the date of receipt.
171 (c) The Division of Medicaid's fiscal agent must pay
172 ninety-nine percent (99%) of all clean claims within ninety (90)
173 days of the date of receipt.
174 (d) The Division of Medicaid's fiscal agent must pay
175 all other claims within twelve (12) months of the date of receipt.
176 (e) If a claim is neither paid nor denied for valid and
177 proper reasons by the end of the time periods as specified above,
178 the Division of Medicaid's fiscal agent must pay the provider
179 interest on the claim at the rate of one and one-half percent
180 (1-1/2%) per month on the amount of such claim until it is finally
181 settled or adjudicated.
182 (3) The date of receipt is the date the fiscal agent
183 receives the claim as indicated by its date stamp on the claim or,
184 for those claims filed electronically, the date of receipt is the
185 date of transmission.
186 (4) The date of payment is the date of the check or, for
187 those claims paid by electronic funds transfer, the date of the
188 transfer.
189 (5) The above specified time limitations do not apply in the
190 following circumstances:
191 (a) Retroactive adjustments paid to providers
192 reimbursed under a retrospective payment system;
193 (b) If a claim for payment under Medicare has been
194 filed in a timely manner, the fiscal agent may pay a Medicaid
195 claim relating to the same services within six (6) months after
196 it, or the provider, receives notice of the disposition of the
197 Medicare claim;
198 (c) Claims from providers under investigation for fraud
199 or abuse; and

200 (d) The Division of Medicaid and/or its fiscal agent
201 may make payments at any time in accordance with a court order, to
202 carry out hearing decisions or corrective actions taken to resolve
203 a dispute, or to extend the benefits of a hearing decision,
204 corrective action, or court order to others in the same situation
205 as those directly affected by it.
206 *** * ***
207 SECTION 5. Section 43-13-115, Mississippi Code of 1972, is
208 amended as follows:
209 43-13-115. Recipients of medical assistance shall be the
210 following persons only:
211 (1) Who are qualified for public assistance grants under
212 provisions of Title IV-A and E of the federal Social Security Act,
213 as amended, <u>as determined by the State Department of Human</u>
214 <u>Services,</u> including those statutorily deemed to be IV-A as
215 determined by *** * *** the Division of Medicaid, but not optional
216 groups <u>except as</u> specifically covered in this section. For the
217 purposes of this paragraph (1) and paragraphs *** * *** (8), *** * ***
218 (17) and (18) of this section, any reference to Title IV-A or to
219 Part A of Title IV of the federal Social Security Act, as amended,
220 or the state plan under Title IV-A or Part A of Title IV, shall be
221 considered as a reference to Title IV-A of the federal Social
222 Security Act, as amended, and the state plan under Title IV-A,
223 including the income and resource standards and methodologies
224 under Title IV-A and the state plan, as they existed on July 16,
225 1996.
226 (2) Those qualified for Supplemental Security Income (SSI)
227 benefits under Title XVI of the federal Social Security Act, as
228 amended. The eligibility of individuals covered in this paragraph
229 shall be determined by the Social Security Administration and
230 certified to the Division of Medicaid.
231 (3) *** * ***
232 (4) *** * ***
233 (5) A child born on or after October 1, 1984, to a woman

234 eligible for and receiving medical assistance under the state plan
235 on the date of the child's birth shall be deemed to have applied
236 for medical assistance and to have been found eligible for such
237 assistance under such plan on the date of such birth and will
238 remain eligible for such assistance for a period of one (1) year
239 so long as the child is a member of the woman's household and the
240 woman remains eligible for such assistance or would be eligible
241 for assistance if pregnant. The eligibility of individuals
242 covered in this paragraph shall be determined by *** * *** the
243 Division of Medicaid.

244 (6) Children certified by the State Department of Human
245 Services to the Division of Medicaid of whom the state and county
246 human services agency has custody and financial responsibility,
247 and children who are in adoptions subsidized in full or part by
248 the Department of Human Services, who are approvable under Title
249 XIX of the Medicaid program.

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

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

266 (8) Children under eighteen (18) years of age and pregnant
267 women (including those in intact families) who meet the AFDC

268 financial standards of the state plan approved under Title IV-A of
269 the federal Social Security Act, as amended. The eligibility of
270 children covered under this paragraph shall be determined by *** * ***
271 the Division of Medicaid.

272 (9) Individuals who are:

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

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

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

284 The eligibility of individuals covered in (a), (b) and (c) of
285 this paragraph shall be determined by the <u>Division of Medicaid</u>.

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

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

299 (a) Whose income does not exceed one hundred percent
300 (100%) of the nonfarm official poverty line as defined by the
301 Office of Management and Budget and revised annually.

302 (b) Whose resources do not exceed two hundred percent
303 (200%) of the amount allowed under the Supplemental Security
304 Income (SSI) program.
305 The eligibility of individuals covered under this paragraph
306 shall be determined by the Division of Medicaid, and such
307 individuals determined eligible shall receive the same Medicaid
308 services as other categorical eligible individuals.
309 (12) Individuals who are qualified Medicare beneficiaries
310 (QMB) entitled to Part A Medicare as defined under Section 301,
311 Public Law 100-360, known as the Medicare Catastrophic Coverage
312 Act of 1988, and who meet the following criteria:
313 *** * *** Whose income does not exceed one hundred percent
314 (100%) of the nonfarm official poverty line as defined by the
315 Office of Management and Budget and revised annually.
316 *** * ***
317 The eligibility of individuals covered under this paragraph
318 shall be determined by the Division of Medicaid, and such
319 individuals determined eligible shall receive Medicare
320 cost-sharing expenses only as more fully defined by the Medicare
321 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
322 1997.
323 (13) (a) Individuals who are entitled to Medicare Part A as
324 defined in Section 4501 of the Omnibus Budget Reconciliation Act
325 of 1990, and *** * *** whose income does not exceed the percentage of
326 the nonfarm official poverty line as defined by the Office of
327 Management and Budget and revised annually which, on or after:
328 (i) January 1, 1993, is one hundred ten percent
329 (110%); and
330 (ii) January 1, 1995, is one hundred twenty
331 percent (120%).
332 (b) Individuals entitled to Part A of Medicare, with
333 income above one hundred twenty percent (120%), but less than one
334 hundred thirty-five percent (135%) of the federal poverty level,
335 and not otherwise eligible for Medicaid. Eligibility for Medicaid

336 benefits is limited to full payment of Medicare Part B premiums.
337 The number of eligible individuals is limited by the availability
338 of the federal capped allocation at one hundred percent (100%) of
339 federal matching funds, as more fully defined in the Balanced
340 Budget Act of 1997.
341 (c) Individuals entitled to Part A of Medicare, with
342 income of at least one hundred thirty-five percent (135%), but not
343 exceeding one hundred seventy-five percent (175%) of the federal
344 poverty level, and not otherwise eligible for Medicaid.
345 Eligibility for Medicaid benefits is limited to partial payment of
346 Medicare Part B premiums. The number of eligible individuals is
347 limited by the availability of the federal capped allocation of
348 one hundred percent (100%) federal matching funds, as more fully
349 defined in the Balanced Budget Act of 1997.
350 The eligibility of individuals covered under this paragraph
351 shall be determined by the Division of Medicaid *** .
352 (14) ***
353 (15) Disabled workers who are eligible to enroll in Part A
354 Medicare as required by Public Law 101-239, known as the Omnibus
355 Budget Reconciliation Act of 1989, and whose income does not
356 exceed two hundred percent (200%) of the federal poverty level as
357 determined in accordance with the Supplemental Security Income
358 (SSI) program. The eligibility of individuals covered under this
359 paragraph shall be determined by the Division of Medicaid and such
360 individuals shall be entitled to buy-in coverage of Medicare Part
361 A premiums only under the provisions of this paragraph (15).
362 (16) In accordance with the terms and conditions of approved
363 Title XIX waiver from the United States Department of Health and
364 Human Services, persons provided home- and community-based
365 services who are physically disabled and certified by the Division
366 of Medicaid as eligible due to applying the income and deeming
367 requirements as if they were institutionalized.
368 (17) In accordance with the terms of the federal Personal
369 Responsibility and Work Opportunity Reconciliation Act of 1996

370 (Public Law 104-193), persons who become ineligible for assistance
371 under Title IV-A of the federal Social Security Act, as amended
372 because of increased income from or hours of employment of the
373 caretaker relative or because of the expiration of the applicable
374 earned income disregards, who were eligible for Medicaid for at
375 least three (3) of the six (6) months preceding the month in which
376 such ineligibility begins, shall be eligible for Medicaid
377 assistance for up to twenty-four (24) months; however, Medicaid
378 assistance for more than twelve (12) months may be provided only
379 if a federal waiver is obtained to provide such assistance for
380 more than twelve (12) months and federal and state funds are
381 available to provide such assistance.

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

391 (19) Individuals enrolled in a Medicaid managed care program
392 shall remain eligible for Medicaid benefits until the end of a
393 period of six (6) months following an eligibility determination.

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

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

401 43-13-116. (1) It shall be the duty of the Division of
402 Medicaid to fully implement and carry out the administrative
403 functions of determining the eligibility of those persons who

404 qualify for medical assistance under Section 43-13-115.
405 (2) In determining Medicaid eligibility, the Division of
406 Medicaid is authorized to enter into an agreement with the
407 Secretary of the Department of Health and Human Services for the
408 purpose of securing the transfer of eligibility information from
409 the Social Security Administration on those individuals receiving
410 supplemental security income benefits under the federal Social
411 Security Act and any other information necessary in determining
412 Medicaid eligibility. The Division of Medicaid is further
413 empowered to enter into contractual arrangements with its fiscal
414 agent or with the State Department of Human Services in securing
415 electronic data processing support as may be necessary.
416 (3) Administrative hearings shall be available to any
417 applicant who requests it because his or her claim of eligibility
418 for services is denied or is not acted upon with reasonable
419 promptness or by any recipient who requests it because he or she
420 believes the agency has erroneously taken action to deny, reduce,
421 or terminate benefits. The agency need not grant a hearing if the
422 sole issue is a federal or state law requiring an automatic change
423 adversely affecting some or all recipients. Eligibility
424 determinations that are made by other agencies and certified to
425 the Division of Medicaid pursuant to Section 43-13-115 are not
426 subject to the administrative hearing procedures of the Division
427 of Medicaid but are subject to the administrative hearing
428 procedures of the agency that determined eligibility.
429 (a) A request may be made either for a local regional
430 office hearing or a state office hearing when the local regional
431 office has made the initial decision that the claimant seeks to
432 appeal or when the regional office has not acted with reasonable
433 promptness in making a decision on a claim for eligibility or
434 services. The only exception to requesting a local hearing is
435 when the issue under appeal involves either (i) a disability or
436 blindness denial, or termination, or (ii) a level of care denial
437 or termination for a disabled child living at home. An appeal

438 <u>involving disability, blindness or level of care must be handled</u>
439 <u>as a state level hearing.</u> The decision from the local hearing may
440 be appealed to the state office for a state hearing. A decision
441 to deny, reduce or terminate benefits that is initially made at
442 the state office may be appealed by requesting a state hearing.
443 (b) A request for a hearing, either state or local,
444 must be made in writing by the claimant or claimant's legal
445 representative. "Legal representative" includes the claimant's
446 authorized representative, an attorney retained by the claimant or
447 claimant's family to represent the claimant, a paralegal
448 representative with a legal aid services, a parent of a minor
449 child if the claimant is a child, a legal guardian or conservator
450 or an individual with power of attorney for the claimant. The
451 claimant may also be represented by anyone that he or she so
452 designates but must give the designation to the Medicaid regional
453 office or state office in writing, if the person is not the legal
454 representative, legal guardian, or authorized representative.
455 (c) The claimant may make a request for a hearing in
456 person at the regional office but an oral request must be put into
457 written form. Regional office staff will determine from the
458 claimant if a local or state hearing is requested and assist the
459 claimant in completing and signing the appropriate form. Regional
460 office staff may forward a state hearing request to the
461 appropriate division in the state office or the claimant may mail
462 the form to the address listed on the form. The claimant may make
463 a written request for a hearing by letter. A simple statement
464 requesting a hearing that is signed by the claimant or legal
465 representative is sufficient; however, if possible, the claimant
466 should state the reason for the request. The letter may be mailed
467 to the regional office or it may be mailed to the state office. If
468 the letter does not specify the type of hearing desired, local or
469 state, Medicaid staff will attempt to contact the claimant to
470 determine the level of hearing desired. If contact cannot be made
471 within three (3) days of receipt of the request, the request will

472 be assumed to be for a local hearing and scheduled accordingly. A
473 hearing will not be scheduled until either a letter or the
474 appropriate form is received by the regional or state office.
475 (d) When both members of a couple wish to appeal an
476 action or inaction by the agency that affects both applications or
477 cases similarly and arose from the same issue, one or both may
478 file the request for hearing, both may present evidence at the
479 hearing, and the agency's decision will be applicable to both. If
480 both file a request for hearing, two (2) hearings will be
481 registered but they will be conducted on the same day and in the
482 same place, either consecutively or jointly, as the couple wishes.
483 If they so desire, only one of the couple need attend the hearing.
484 (e) The procedure for administrative hearings shall be
485 as follows:
486 (i) The claimant has thirty (30) days from the
487 date the agency mails the appropriate notice to the claimant of
488 its decision regarding eligibility, services, or benefits to
489 request either a state or local hearing. This time period may be
490 extended if the claimant can show good cause for not filing within
491 thirty (30) days. Good cause includes, but may not be limited to,
492 illness, failure to receive the notice, being out of state, or
493 some other reasonable explanation. If good cause can be shown, a
494 late request may be accepted provided the facts in the case remain
495 the same. If a claimant's circumstances have changed or if good
496 cause for filing a request beyond thirty (30) days is not shown, a
497 hearing request will not be accepted. If the claimant wishes to
498 have eligibility reconsidered, he or she may reapply.
499 (ii) If a claimant or representative requests a
500 hearing in writing during the advance notice period before
501 benefits are reduced or terminated, benefits must be continued or
502 reinstated to the benefit level in effect before the effective
503 date of the adverse action. Benefits will continue at the
504 original level until the final hearing decision is rendered. Any
505 hearing requested after the advance notice period will not be

506 accepted as a timely request in order for continuation of benefits
507 to apply.
508 (iii) Upon receipt of a written request for a
509 hearing, the request will be acknowledged in writing within twenty
510 (20) days and a hearing scheduled. The claimant or representative
511 will be given at least five (5) days' advance notice of the
512 hearing date. <u>The local and/or state level hearings will be held</u>
513 <u>by telephone unless, at the hearing officer's discretion, it is</u>
514 <u>determined that an in-person hearing is necessary.</u> If a local
515 hearing is requested, the regional office will notify the claimant
516 or representative in writing of the time *** * *** of the local
517 hearing. If a state hearing is requested, the state office will
518 notify the claimant or representative in writing of the time *** * ***
519 of the state hearing. <u>If an in-person hearing is necessary</u>, local
520 hearings will be held at the regional office and state hearings
521 will be held at the state office unless other arrangements are
522 necessitated by the claimant's inability to travel.
523 (iv) All persons attending a hearing will attend
524 for the purpose of giving information on behalf of the claimant or
525 rendering the claimant assistance in some other way, or for the
526 purpose of representing the Division of Medicaid.
527 (v) A state or local hearing request may be
528 withdrawn at any time before the scheduled hearing, or after the
529 hearing is held but before a decision is rendered. The withdrawal
530 must be in writing and signed by the claimant or representative.
531 A hearing request will be considered abandoned if the claimant or
532 representative fails to appear at a scheduled hearing without good
533 cause. If no one appears for a hearing, the appropriate office
534 will notify the claimant in writing that the hearing is dismissed
535 unless good cause is shown for not attending. The proposed agency
536 action will be taken on the case following failure to appear for a
537 hearing if the action has not already been effected.
538 (vi) The claimant or his representative has the
539 following rights in connection with a local or state hearing:

540 (A) The right to examine at a reasonable time
541 before the date of the hearing and during the hearing the content
542 of the claimant's case record;
543 (B) The right to have legal representation at
544 the hearing and to bring witnesses;
545 (C) The right to produce documentary evidence
546 and establish all facts and circumstances concerning eligibility,
547 services, or benefits;
548 (D) The right to present an argument without
549 undue interference;
550 (E) The right to question or refute any
551 testimony or evidence including an opportunity to confront and
552 cross-examine adverse witnesses.
553 (vii) When a request for a local hearing is
554 received by the regional office or if the regional office is
555 notified by the state office that a local hearing has been
556 requested, the Medicaid specialist supervisor in the regional
557 office will review the case record, re-examine the action taken on
558 the case, and determine if policy and procedures have been
559 followed. If any adjustments or corrections should be made, the
560 Medicaid specialist supervisor will ensure that corrective action
561 is taken. If the request for hearing was timely made such that
562 continuation of benefits applies, the Medicaid specialist
563 supervisor will ensure that benefits continue at the level before
564 the proposed adverse action that is the subject of the appeal.
565 The Medicaid specialist supervisor will also ensure that all
566 needed information, verification, and evidence is in the case
567 record for the hearing.
568 (viii) When a state hearing is requested that
569 appeals the action or inaction of a regional office, the regional
570 office will prepare copies of the case record and forward it to
571 the appropriate division in the state office no later than five
572 (5) days after receipt of the request for a state hearing. The
573 original case record will remain in the regional office. Either

574 the original case record in the regional office or the copy
575 forwarded to the state office will be available for inspection by
576 the claimant or claimant's representative a reasonable time before
577 the date of the hearing.
578 (ix) The Medicaid specialist supervisor will serve
579 as the hearing officer for a local hearing unless the Medicaid
580 specialist supervisor actually participated in the eligibility,
581 benefits, or services decision under appeal, in which case the
582 Medicaid specialist supervisor must appoint a Medicaid specialist
583 in the regional office who did not actually participate in the
584 decision under appeal to serve as hearing officer. The local
585 hearing will be an informal proceeding in which the claimant or
586 representative may present new or additional information, may
587 question the action taken on the client's case, and will hear an
588 explanation from agency staff as to the regulations and
589 requirements that were applied to claimant's case in making the
590 decision.
591 (x) After the hearing, the hearing officer will
592 prepare a written summary of the hearing procedure and file it
593 with the case record. The hearing officer will consider the facts
594 presented at the local hearing in reaching a decision. The
595 claimant will be notified of the local hearing decision on the
596 appropriate form that will state clearly the reason for the
597 decision, the policy that governs the decision, the claimant's
598 right to appeal the decision to the state office, and, if the
599 original adverse action is upheld, the new effective date of the
600 reduction or termination of benefits or services if continuation
601 of benefits applied during the hearing process. The new effective
602 date of the reduction or termination of benefits or services must
603 be at the end of the fifteen-day advance notice period from the
604 mailing date of the notice of hearing decision. The notice to
605 claimant will be made part of the case record.
606 (xi) The claimant has the right to appeal a local
607 hearing decision by requesting a state hearing in writing within

608 fifteen (15) days of the mailing date of the notice of local
609 hearing decision. The state hearing request should be made to the
610 regional office. If benefits have been continued pending the
611 local hearing process, then benefits will continue throughout the
612 fifteen-day advance notice period for an adverse local hearing
613 decision. If a state hearing is timely requested within the
614 fifteen-day period, then benefits will continue pending the state
615 hearing process. State hearings requested after the fifteen-day
616 local hearing advance notice period will not be accepted unless
617 the initial thirty-day period for filing a hearing request has not
618 expired because the local hearing was held early, in which case a
619 state hearing request will be accepted as timely within the number
620 of days remaining of the unexpired initial thirty-day period in
621 addition to the fifteen-day time period. Continuation of benefits
622 during the state hearing process, however, will only apply if the
623 state hearing request is received within the fifteen-day advance
624 notice period.

625 (xii) When a request for a state hearing is
626 received in the regional office, the request will be made part of
627 the case record and the regional office will prepare the case
628 record and forward it to the appropriate division in the state
629 office within five (5) days of receipt of the state hearing
630 request. A request for a state hearing received in the state
631 office will be forwarded to the regional office for inclusion in
632 the case record and the regional office will prepare the case
633 record and forward it to the appropriate division in the state
634 office within five (5) days of receipt of the state hearing
635 request.

636 (xiii) Upon receipt of the hearing record, an
637 impartial hearing officer will be assigned to hear the case either
638 by the Executive Director of the Division of Medicaid or his or
639 her designee. Hearing officers will be individuals with
640 appropriate expertise employed by the division and who have not
641 been involved in any way with the action or decision on appeal in

642 the case. The hearing officer will review the case record and if
643 the review shows that an error was made in the action of the
644 agency or in the interpretation of policy, or that a change of
645 policy has been made, the hearing officer will discuss these
646 matters with the appropriate agency personnel and request that an
647 appropriate adjustment be made. Appropriate agency personnel will
648 discuss the matter with the claimant and if the claimant is
649 agreeable to the adjustment of the claim, then agency personnel
650 will request in writing dismissal of the hearing and the reason
651 therefor, to be placed in the case record. If the hearing is to
652 go forward, it shall be scheduled by the hearing officer in the
653 manner set forth in subparagraph (iii) of this paragraph (e).
654 (xiv) In conducting the hearing, the state hearing
655 officer will inform those present of the following:
656 (A) That the hearing will be recorded on tape
657 and that a transcript of the proceedings will be typed for the
658 record;
659 (B) The action taken by the agency which
660 prompted the appeal;
661 (C) An explanation of the claimant's rights
662 during the hearing as outlined in subparagraph (vi) of this
663 paragraph (e);
664 (D) That the purpose of the hearing is for
665 the claimant to express dissatisfaction and present additional
666 information or evidence;
667 (E) That the case record is available for
668 review by the claimant or representative during the hearing;
669 (F) That the final hearing decision will be
670 rendered by the Executive Director of the Division of Medicaid on
671 the basis of facts presented at the hearing and the case record
672 and that the claimant will be notified by letter of the final
673 decision.
674 (xv) During the hearing, the claimant and/or
675 representative will be allowed an opportunity to make a full

676 statement concerning the appeal and will be assisted, if
677 necessary, in disclosing all information on which the claim is
678 based. All persons representing the claimant and those
679 representing the Division of Medicaid will have the opportunity to
680 state all facts pertinent to the appeal. The hearing officer may
681 recess or continue the hearing for a reasonable time should
682 additional information or facts be required or if some change in
683 the claimant's circumstances occurs during the hearing process
684 which impacts the appeal. When all information has been
685 presented, the hearing officer will close the hearing and stop the
686 recorder.

687 (xvi) Immediately following the hearing the
688 hearing tape will be transcribed and a copy of the transcription
689 forwarded to the regional office for filing in the case record.
690 As soon as possible, the hearing officer shall review the evidence
691 and record of the proceedings, testimony, exhibits, and other
692 supporting documents, prepare a written summary of the facts as
693 the hearing officer finds them, and prepare a written
694 recommendation of action to be taken by the agency, citing
695 appropriate policy and regulations that govern the recommendation.
696 The decision cannot be based on any material, oral or written, not
697 available to the claimant before or during the hearing. The
698 hearing officer's recommendation will become part of the case
699 record which will be submitted to the Executive Director of the
700 Division of Medicaid for further review and decision.

701 (xvii) The Executive Director of the Division of
702 Medicaid, upon review of the recommendation, proceedings and the
703 record, may sustain the recommendation of the hearing officer,
704 reject the same, or remand the matter to the hearing officer to
705 take additional testimony and evidence, in which case, the hearing
706 officer thereafter shall submit to the executive director a new
707 recommendation. The executive director shall prepare a written
708 decision summarizing the facts and identifying policies and
709 regulations that support the decision, which shall be mailed to

710 the claimant and the representative, with a copy to the regional
711 office if appropriate, as soon as possible after submission of a
712 recommendation by the hearing officer. The decision notice will
713 specify any action to be taken by the agency, specify any revised
714 eligibility dates or, if continuation of benefits applies, will
715 notify the claimant of the new effective date of reduction or
716 termination of benefits or services, which will be fifteen (15)
717 days from the mailing date of the notice of decision. The
718 decision rendered by the Executive Director of the Division of
719 Medicaid is final and binding. The claimant is entitled to seek
720 judicial review in a court of proper jurisdiction.
721 (xviii) The Division of Medicaid must take final
722 administrative action on a hearing, whether state or local, within
723 ninety (90) days from the date of the initial request for a
724 hearing.
725 (xix) A group hearing may be held for a number of
726 claimants under the following circumstances:
727 (A) The Division of Medicaid may consolidate
728 the cases and conduct a single group hearing when the only issue
729 involved is one of a single law or agency policy;
730 (B) The claimants may request a group hearing
731 when there is one issue of agency policy common to all of them.
732 In all group hearings, whether initiated by the Division of
733 Medicaid or by the claimants, the policies governing fair hearings
734 must be followed. Each claimant in a group hearing must be
735 permitted to present his or her own case and be represented by his
736 or her own representative, or to withdraw from the group hearing
737 and have his or her appeal heard individually. As in individual
738 hearings, the hearing will be conducted only on the issue being
739 appealed, and each claimant will be expected to keep individual
740 testimony within a reasonable time frame as a matter of
741 consideration to the other claimants involved.
742 (xx) Any specific matter necessitating an
743 administrative hearing not otherwise provided under this article

744 or agency policy shall be afforded under the hearing procedures as
745 outlined above. If the specific time frames of such a unique
746 matter relating to requesting, granting, and concluding of the
747 hearing is contrary to the time frames as set out in the hearing
748 procedures above, the specific time frames will govern over the
749 time frames as set out within these procedures.

750 (4) The Executive Director of the Division of Medicaid, with
751 the approval of the Governor, shall be authorized to employ
752 eligibility, technical, clerical and supportive staff as may be
753 required in carrying out and fully implementing the determination
754 of Medicaid eligibility, including conducting quality control
755 reviews and the investigation of the improper receipt of medical
756 assistance. Staffing needs will be set forth in the annual
757 appropriation act for the division. Additional office space as
758 needed in performing eligibility, quality control and
759 investigative functions shall be obtained by the division.

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

762 43-13-117. Medical assistance as authorized by this article
763 shall include payment of part or all of the costs, at the
764 discretion of the division or its successor, with approval of the
765 Governor, of the following types of care and services rendered to
766 eligible applicants who shall have been determined to be eligible
767 for such care and services, within the limits of state
768 appropriations and federal matching funds:

769 (1) Inpatient hospital services.

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

775 (b) From and after July 1, 1994, the Executive Director
776 of the Division of Medicaid shall amend the Mississippi Title XIX
777 Inpatient Hospital Reimbursement Plan to remove the occupancy rate

778 penalty from the calculation of the Medicaid Capital Cost
779 Component utilized to determine total hospital costs allocated to
780 the Medicaid Program.
781 (c) Rates for out-of-state hospitals participating in
782 the Mississippi Medicaid program may be revised consistent with
783 federal law.
784 (d) The division shall evaluate the fiscal impact of
785 conversion to Medicare reimbursement methodologies for both
786 inpatient and outpatient services, and shall implement these
787 methodologies if they are determined to be cost effective.
788 (e) The division may eliminate graduate medical
789 education payments in the calculation of caps and average rates
790 for hospitals.
791 (2) Outpatient hospital services. Provided that where the
792 same services are reimbursed as clinic services, the division may
793 revise the rate or methodology of outpatient reimbursement to
794 maintain consistency, efficiency, economy and quality of care.
795 (3) Laboratory and X-ray services.
796 (4) Nursing facility services.
797 (a) The division shall make full payment to nursing
798 facilities for each day, not exceeding forty-five (45) days per
799 year, that a patient is absent from the facility on home leave.
800 However, before payment may be made for more than eighteen (18)
801 home leave days in a year for a patient, the patient must have
802 written authorization from a physician stating that the patient is
803 physically and mentally able to be away from the facility on home
804 leave. Such authorization must be filed with the division before
805 it will be effective and the authorization shall be effective for
806 three (3) months from the date it is received by the division,
807 unless it is revoked earlier by the physician because of a change
808 in the condition of the patient.
809 (b) From and after July 1, 1997, the division shall
810 implement the integrated case-mix payment and quality monitoring
811 system *** * ***, which includes the fair rental system for property

812 costs and in which recapture of depreciation is eliminated. The
813 division may reduce the payment * * * for hospital leave and
814 therapeutic home leave days to the lower of the case-mix category
815 as computed for the resident on leave using the assessment being
816 utilized for payment at that point in time, or a case-mix score of
817 1.000 for nursing facilities, shall compute case-mix scores of
818 residents so that only services provided at the nursing facility
819 are considered in calculating a facility's per diem * * *. * * *
820 The division is authorized to limit allowable management fees and
821 home office costs to either three percent (3%), five percent (5%)
822 or seven percent (7%) of other allowable costs, including
823 allowable therapy costs and property costs, based on the types of
824 management services provided, as follows:
825 A maximum of up to three percent (3%) shall be allowed where
826 centralized managerial and administrative services are provided by
827 the management company or home office.
828 A maximum of up to five percent (5%) shall be allowed where
829 centralized managerial and administrative services and limited
830 professional and consultant services are provided.
831 A maximum of up to seven percent (7%) shall be allowed where
832 a full spectrum of centralized managerial services, administrative
833 services, professional services and consultant services are
834 provided.
835 (c) From and after July 1, 2000, all state-owned
836 nursing facilities shall be reimbursed on a full reasonable cost
837 basis. * * *
838 (d) The Division of Medicaid shall develop and
839 implement a nursing facility preadmission screening program for
840 Medicaid beneficiaries and applicants. The nursing facility
841 preadmission screening program shall be conducted by a screening
842 team consisting of two (2) members, with a licensed physician
843 available for consultation. Nursing facilities shall provide an
844 individual who applies for admission to the nursing facility or
845 the individual's parent or guardian, if the individual is not

846 competent, a notification in writing on forms prepared by the
847 division of the following:
848 (i) No Medicaid funds shall be paid for nursing
849 facility care for Medicaid beneficiaries or applicants admitted to
850 nursing facilities on or after July 1, 1999, who have failed to
851 participate in the nursing facility preadmission screening
852 program.
853 (ii) The nursing facility preadmission screening
854 program consists of an assessment of the applicant's need for care
855 in a nursing facility made by a team of individuals familiar with
856 the needs of individuals seeking admissions to nursing facilities.
857 Placement in a nursing facility may not be denied by the
858 screening team if any of the following conditions exist:
859 (i) Community services that would be more
860 appropriate than care in a nursing facility are not actually
861 available;
862 (ii) The applicant chooses not to receive the
863 appropriate community service.
864 An applicant aggrieved by a determination of the screening
865 team may appeal the determination under rules and procedures
866 adopted by the division.
867 The division shall make full payment for nursing facility
868 preadmission screening team services.
869 The division shall apply for necessary federal waivers to
870 assure that additional services, including assisted living
871 services, are made available to applicants for nursing facility
872 care.
873 (e) Nursing facilities must maintain a waiting list
874 based on the date of request for placement from the oldest date to
875 the most recent date, and the facility must only accept patients
876 for admission in the order of the facility's waiting list. A
877 person at the top of the waiting list that is not ready to be
878 placed in the facility at the time a bed comes available will have
879 the option of staying at the top of the waiting list, removing

880 his/her name from the waiting list, or moving to the bottom of the
881 waiting list.
882 (f) Nursing facilities are prohibited from requiring
883 any nursing home resident or any resident's family member or
884 representative to give advance notice to the facility before the
885 resident is discharged, and from requiring payment from the
886 resident, family member or representative for any days after the
887 resident's discharge date if advance notice of the discharge is
888 not given by the family.
889 (g) When a facility of a category that does not require
890 a certificate of need for construction and that could not be
891 eligible for Medicaid reimbursement is constructed to nursing
892 facility specifications for licensure and certification, and the
893 facility is subsequently converted to a nursing facility pursuant
894 to a certificate of need that authorizes conversion only and the
895 applicant for the certificate of need was assessed an application
896 review fee based on capital expenditures incurred in constructing
897 the facility, the division shall allow reimbursement for capital
898 expenditures necessary for construction of the facility that were
899 incurred within the twenty-four (24) consecutive calendar months
900 immediately preceding the date that the certificate of need
901 authorizing such conversion was issued, to the same extent that
902 reimbursement would be allowed for construction of a new nursing
903 facility pursuant to a certificate of need that authorizes such
904 construction. The reimbursement authorized in this subparagraph
905 (g) may be made only to facilities the construction of which was
906 completed after June 30, 1989. Before the division shall be
907 authorized to make the reimbursement authorized in this
908 subparagraph (g), the division first must have received approval
909 from the Health Care Financing Administration of the United States
910 Department of Health and Human Services of the change in the state
911 Medicaid plan providing for such reimbursement.
912 (5) Periodic screening and diagnostic services for
913 individuals under age twenty-one (21) years as are needed to

914 identify physical and mental defects and to provide health care
915 treatment and other measures designed to correct or ameliorate
916 defects and physical and mental illness and conditions discovered
917 by the screening services regardless of whether these services are
918 included in the state plan. The division may include in its
919 periodic screening and diagnostic program those discretionary
920 services authorized under the federal regulations adopted to
921 implement Title XIX of the federal Social Security Act, as
922 amended. The division, in obtaining physical therapy services,
923 occupational therapy services, and services for individuals with
924 speech, hearing and language disorders, may enter into a
925 cooperative agreement with the State Department of Education for
926 the provision of such services to handicapped students by public
927 school districts using state funds which are provided from the
928 appropriation to the Department of Education to obtain federal
929 matching funds through the division. The division, in obtaining
930 medical and psychological evaluations for children in the custody
931 of the State Department of Human Services may enter into a
932 cooperative agreement with the State Department of Human Services
933 for the provision of such services using state funds which are
934 provided from the appropriation to the Department of Human
935 Services to obtain federal matching funds through the division.

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

940 The division shall develop and implement a plan to increase
941 the participation of recipients and providers in the periodic
942 screening and diagnostic services program established under this
943 paragraph (5).

944 (6) Physician's services. * * * Fees for physicians'
945 services shall be reimbursed at eighty (80%) of the current rate
946 established * * * under Medicare (Title XVIII of the Social
947 Security Act), as amended, and the division may adjust the

948 physician's reimbursement schedule to reflect the differences in
949 relative value between Medicaid and Medicare. The division shall
950 update the fee schedule annually.
951 (7) (a) Home health services for eligible persons, not to
952 exceed in cost the prevailing cost of nursing facility services,
953 not to exceed sixty (60) visits per year. The Division of
954 Medicaid may require home health service providers to obtain a
955 surety bond in the amount and to the specifications as established
956 under the Balanced Budget Act 1997.
957 (b) The division may revise reimbursement for home
958 health services in order to establish equity between reimbursement
959 for home health services and reimbursement for institutional
960 services within the Medicaid program. *** * ***
961 (8) Emergency medical transportation services. On January
962 1, 1994, emergency medical transportation services shall be
963 reimbursed at seventy percent (70%) of the rate established under
964 Medicare (Title XVIII of the Social Security Act), as amended.
965 "Emergency medical transportation services" shall mean, but shall
966 not be limited to, the following services by a properly permitted
967 ambulance operated by a properly licensed provider in accordance
968 with the Emergency Medical Services Act of 1974 (Section 41-59-1
969 et seq.): (i) basic life support, (ii) advanced life support,
970 (iii) mileage, (iv) oxygen, (v) intravenous fluids, (vi)
971 disposable supplies, (vii) similar services.
972 (9) Legend and other drugs as may be determined by the
973 division. The division may implement a program of prior approval
974 for drugs to the extent permitted by law. Payment by the division
975 for covered multiple source drugs shall be limited to the lower of
976 the upper limits established and published by the Health Care
977 Financing Administration (HCFA) plus a dispensing fee of Four
978 Dollars and Ninety-one Cents ($4.91), or the estimated acquisition
979 cost (EAC) as determined by the division plus a dispensing fee of
980 Four Dollars and Ninety-one Cents ($4.91), or the providers' usual
981 and customary charge to the general public. The division shall

982 allow five (5) prescriptions per month for noninstitutionalized
983 Medicaid recipients.
984 Payment for other covered drugs, other than multiple source
985 drugs with HCFA upper limits, shall not exceed the lower of the
986 estimated acquisition cost as determined by the division plus a
987 dispensing fee of Four Dollars and Ninety-one Cents ($4.91) or the
988 providers' usual and customary charge to the general public.
989 Payment for nonlegend or over-the-counter drugs covered on
990 the division's formulary shall be reimbursed at the lower of the
991 division's estimated shelf price or the providers' usual and
992 customary charge to the general public. No dispensing fee shall
993 be paid.
994 The division shall develop and implement a program of payment
995 for additional pharmacist services, with payment to be based on
996 demonstrated savings, but in no case shall the total payment
997 exceed twice the amount of the dispensing fee.
998 As used in this paragraph (9), "estimated acquisition cost"
999 means the division's best estimate of what price providers
1000 generally are paying for a drug in the package size that providers
1001 buy most frequently. Product selection shall be made in
1002 compliance with existing state law; however, the division may
1003 reimburse as if the prescription had been filled under the generic
1004 name. The division may provide otherwise in the case of specified
1005 drugs when the consensus of competent medical advice is that
1006 trademarked drugs are substantially more effective.
1007 (10) Dental care that is an adjunct to treatment of an acute
1008 medical or surgical condition; services of oral surgeons and
1009 dentists in connection with surgery related to the jaw or any
1010 structure contiguous to the jaw or the reduction of any fracture
1011 of the jaw or any facial bone; and emergency dental extractions
1012 and treatment related thereto. On January 1, 1994, all fees for
1013 dental care and surgery under authority of this paragraph (10)
1014 shall be increased by twenty percent (20%) of the reimbursement
1015 rate as provided in the Dental Services Provider Manual in effect

1016 on December 31, 1993.

1017 (11) Eyeglasses necessitated by reason of eye surgery, and
1018 as prescribed by a physician skilled in diseases of the eye or an
1019 optometrist, whichever the patient may select, or one (1) pair
1020 every five (5) years as prescribed by a physician or an
1021 optometrist, whichever the patient may select.

1022 (12) Intermediate care facility services.

1023 (a) The division shall make full payment to all
1024 intermediate care facilities for the mentally retarded for each
1025 day, not exceeding seventy-two (72) days per year, that a patient
1026 is absent from the facility on home leave. However, before
1027 payment may be made for more than eighteen (18) home leave days in
1028 a year for a patient, the patient must have written authorization
1029 from a physician stating that the patient is physically and
1030 mentally able to be away from the facility on home leave. Such
1031 authorization must be filed with the division before it will be
1032 effective, and the authorization shall be effective for three (3)
1033 months from the date it is received by the division, unless it is
1034 revoked earlier by the physician because of a change in the
1035 condition of the patient.

1036 (b) The division is authorized to limit allowable
1037 management fees and home office costs to either three percent
1038 (3%), five percent (5%) or seven percent (7%) of other allowable
1039 costs, including allowable therapy costs and property costs, based
1040 on the types of management services provided, as follows:

1041 A maximum of up to three percent (3%) shall be allowed where
1042 centralized managerial and administrative services are provided by
1043 the management company or home office.

1044 A maximum of up to five percent (5%) shall be allowed where
1045 centralized managerial and administrative services and limited
1046 professional and consultant services are provided.

1047 A maximum of up to seven percent (7%) shall be allowed where
1048 a full spectrum of centralized managerial services, administrative
1049 services, professional services and consultant services are

1050 provided.

1051 (13) Family planning services, including drugs, supplies and
1052 devices, when such services are under the supervision of a
1053 physician.

1054 (14) Clinic services. Such diagnostic, preventive,
1055 therapeutic, rehabilitative or palliative services furnished to an
1056 outpatient by or under the supervision of a physician or dentist
1057 in a facility which is not a part of a hospital but which is
1058 organized and operated to provide medical care to outpatients.
1059 Clinic services shall include any services reimbursed as
1060 outpatient hospital services which may be rendered in such a
1061 facility, including those that become so after July 1, 1991. *** * ***

1062 (15) Home- and community-based services, as provided under
1063 Title XIX of the federal Social Security Act, as amended, under
1064 waivers, subject to the availability of funds specifically
1065 appropriated therefor by the Legislature. Payment for such
1066 services shall be limited to individuals who would be eligible for
1067 and would otherwise require the level of care provided in a
1068 nursing facility. The division shall certify case management
1069 agencies to provide case management services and provide for home-
1070 and community-based services for eligible individuals under this
1071 paragraph. The home- and community-based services under this
1072 paragraph and the activities performed by certified case
1073 management agencies under this paragraph shall be funded using
1074 state funds that are provided from the appropriation to the
1075 Division of Medicaid and used to match federal funds *** * ***.

1076 (16) Mental health services. Approved therapeutic and case
1077 management services provided by (a) an approved regional mental
1078 health/retardation center established under Sections 41-19-31
1079 through 41-19-39, or by another community mental health service
1080 provider meeting the requirements of the Department of Mental
1081 Health to be an approved mental health/retardation center if
1082 determined necessary by the Department of Mental Health, using
1083 state funds which are provided from the appropriation to the State

1084 Department of Mental Health and used to match federal funds under
1085 a cooperative agreement between the division and the department,
1086 or (b) a facility which is certified by the State Department of
1087 Mental Health to provide therapeutic and case management services,
1088 to be reimbursed on a fee for service basis. Any such services
1089 provided by a facility described in paragraph (b) must have the
1090 prior approval of the division to be reimbursable under this
1091 section. After June 30, 1997, mental health services provided by
1092 regional mental health/retardation centers established under
1093 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
1094 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
1095 psychiatric residential treatment facilities as defined in Section
1096 43-11-1, or by another community mental health service provider
1097 meeting the requirements of the Department of Mental Health to be
1098 an approved mental health/retardation center if determined
1099 necessary by the Department of Mental Health, shall not be
1100 included in or provided under any capitated managed care pilot
1101 program provided for under paragraph (24) of this section.
1102 (17) Durable medical equipment services and medical
1103 supplies * * *. The Division of Medicaid may require durable
1104 medical equipment providers to obtain a surety bond in the amount
1105 and to the specifications as established by the Balanced Budget
1106 Act of 1997.
1107 (18) Notwithstanding any other provision of this section to
1108 the contrary, the division shall make additional reimbursement to
1109 hospitals which serve a disproportionate share of low-income
1110 patients and which meet the federal requirements for such payments
1111 as provided in Section 1923 of the federal Social Security Act and
1112 any applicable regulations.
1113 (19) (a) Perinatal risk management services. The division
1114 shall promulgate regulations to be effective from and after
1115 October 1, 1988, to establish a comprehensive perinatal system for
1116 risk assessment of all pregnant and infant Medicaid recipients and
1117 for management, education and follow-up for those who are

1118 determined to be at risk. Services to be performed include case
1119 management, nutrition assessment/counseling, psychosocial
1120 assessment/counseling and health education. The division shall
1121 set reimbursement rates for providers in conjunction with the
1122 State Department of Health.
1123 (b) Early intervention system services. The division
1124 shall cooperate with the State Department of Health, acting as
1125 lead agency, in the development and implementation of a statewide
1126 system of delivery of early intervention services, pursuant to
1127 Part H of the Individuals with Disabilities Education Act (IDEA).
1128 The State Department of Health shall certify annually in writing
1129 to the director of the division the dollar amount of state early
1130 intervention funds available which shall be utilized as a
1131 certified match for Medicaid matching funds. Those funds then
1132 shall be used to provide expanded targeted case management
1133 services for Medicaid eligible children with special needs who are
1134 eligible for the state's early intervention system.
1135 Qualifications for persons providing service coordination shall be
1136 determined by the State Department of Health and the Division of
1137 Medicaid.
1138 (20) Home- and community-based services for physically
1139 disabled approved services as allowed by a waiver from the U.S.
1140 Department of Health and Human Services for home- and
1141 community-based services for physically disabled people using
1142 state funds which are provided from the appropriation to the State
1143 Department of Rehabilitation Services and used to match federal
1144 funds under a cooperative agreement between the division and the
1145 department, provided that funds for these services are
1146 specifically appropriated to the Department of Rehabilitation
1147 Services.
1148 (21) Nurse practitioner services. Services furnished by a
1149 registered nurse who is licensed and certified by the Mississippi
1150 Board of Nursing as a nurse practitioner including, but not
1151 limited to, nurse anesthetists, nurse midwives, family nurse

1152 practitioners, family planning nurse practitioners, pediatric
1153 nurse practitioners, obstetrics-gynecology nurse practitioners and
1154 neonatal nurse practitioners, under regulations adopted by the
1155 division. Reimbursement for such services shall not exceed ninety
1156 percent (90%) of the reimbursement rate for comparable services
1157 rendered by a physician.

1158 (22) Ambulatory services delivered in federally qualified
1159 health centers and in clinics of the local health departments of
1160 the State Department of Health for individuals eligible for
1161 medical assistance under this article based on reasonable costs as
1162 determined by the division.

1163 (23) Inpatient psychiatric services. Inpatient psychiatric
1164 services to be determined by the division for recipients under age
1165 twenty-one (21) which are provided under the direction of a
1166 physician in an inpatient program in a licensed acute care
1167 psychiatric facility or in a licensed psychiatric residential
1168 treatment facility, before the recipient reaches age twenty-one
1169 (21) or, if the recipient was receiving the services immediately
1170 before he reached age twenty-one (21), before the earlier of the
1171 date he no longer requires the services or the date he reaches age
1172 twenty-two (22), as provided by federal regulations. Recipients
1173 shall be allowed forty-five (45) days per year of psychiatric
1174 services provided in acute care psychiatric facilities, and shall
1175 be allowed unlimited days of psychiatric services provided in
1176 licensed psychiatric residential treatment facilities. <u>The</u>
1177 <u>division is authorized to limit allowable management fees and home</u>
1178 <u>office costs to either three percent (3%), five percent (5%) or</u>
1179 <u>seven percent (7%) of other allowable costs, including allowable</u>
1180 <u>therapy costs and property costs, based on the types of management</u>
1181 <u>services provided, as follows:</u>

1182 <u>A maximum of up to three percent (3%) shall be allowed where</u>
1183 <u>centralized managerial and administrative services are provided by</u>
1184 <u>the management company or home office.</u>

1185 <u>A maximum of up to five percent (5%) shall be allowed where</u>

1186 centralized managerial and administrative services and limited
1187 professional and consultant services are provided.
1188 A maximum of up to seven percent (7%) shall be allowed where
1189 a full spectrum of centralized managerial services, administrative
1190 services, professional services and consultant services are
1191 provided.
1192 (24) Managed care services in a program to be developed by
1193 the division by a public or private provider. Notwithstanding any
1194 other provision in this article to the contrary, the division
1195 shall establish rates of reimbursement to providers rendering care
1196 and services authorized under this section, and may revise such
1197 rates of reimbursement without amendment to this section by the
1198 Legislature for the purpose of achieving effective and accessible
1199 health services, and for responsible containment of costs. * * *
1200 Beginning July 1, 1999, any Medicaid recipient who enrolls or
1201 is already enrolled in this pilot program must remain in the pilot
1202 program for not less than one (1) year before the recipient will
1203 be allowed to disenroll, if this requirement is allowed under a
1204 federal waiver. The division shall apply for any federal waiver
1205 necessary in order to allow it to implement a one-year
1206 disenrollment requirement under this pilot program.
1207 From and after passage of this act, Medicaid eligibility is
1208 guaranteed up to six (6) months for individuals enrolled in a
1209 Medicaid managed care program.
1210 A Medicaid Managed Care Marketing Advisory Committee is
1211 established within the Division of Medicaid, with membership,
1212 responsibilities and per diem compensation to be prescribed by the
1213 Balanced Budget Act of 1997.
1214 (25) Birthing center services.
1215 (26) Hospice care. As used in this paragraph, the term
1216 "hospice care" means a coordinated program of active professional
1217 medical attention within the home and outpatient and inpatient
1218 care which treats the terminally ill patient and family as a unit,
1219 employing a medically directed interdisciplinary team. The

1220 program provides relief of severe pain or other physical symptoms
1221 and supportive care to meet the special needs arising out of
1222 physical, psychological, spiritual, social and economic stresses
1223 which are experienced during the final stages of illness and
1224 during dying and bereavement and meets the Medicare requirements
1225 for participation as a hospice as provided in federal regulations.
1226 (27) Group health plan premiums and cost sharing if it is
1227 cost effective as defined by the Secretary of Health and Human
1228 Services.
1229 (28) Other health insurance premiums which are cost
1230 effective as defined by the Secretary of Health and Human
1231 Services. Medicare eligible must have Medicare Part B before
1232 other insurance premiums can be paid.
1233 (29) The Division of Medicaid may apply for a waiver from
1234 the Department of Health and Human Services for home- and
1235 community-based services for developmentally disabled people using
1236 state funds which are provided from the appropriation to the State
1237 Department of Mental Health and used to match federal funds under
1238 a cooperative agreement between the division and the department,
1239 provided that funds for these services are specifically
1240 appropriated to the Department of Mental Health.
1241 (30) Pediatric skilled nursing services for eligible persons
1242 under twenty-one (21) years of age.
1243 (31) Targeted case management services for children with
1244 special needs, under waivers from the U.S. Department of Health
1245 and Human Services, using state funds that are provided from the
1246 appropriation to the Mississippi Department of Human Services and
1247 used to match federal funds under a cooperative agreement between
1248 the division and the department.
1249 (32) Care and services provided in Christian Science
1250 Sanatoria operated by or listed and certified by The First Church
1251 of Christ Scientist, Boston, Massachusetts, rendered in connection
1252 with treatment by prayer or spiritual means to the extent that
1253 such services are subject to reimbursement under Section 1903 of

1254 the Social Security Act.

1255 (33) Podiatrist services.

1256 (34) * * *

1257 (35) Services and activities authorized in Sections
1258 43-27-101 and 43-27-103, using state funds that are provided from
1259 the appropriation to the State Department of Human Services and
1260 used to match federal funds under a cooperative agreement between
1261 the division and the department.

1262 (36) Nonemergency transportation services for
1263 Medicaid-eligible persons, to be provided by the Division of
1264 Medicaid. The division may contract with additional entities to
1265 administer non-emergency transportation services as it deems
1266 necessary. All providers shall have a valid driver's license,
1267 vehicle inspection sticker, valid vehicle license tags and a
1268 standard liability insurance policy covering the vehicle.

1269 (37) Targeted case management services for individuals with
1270 chronic diseases, with expanded eligibility to cover services to
1271 uninsured recipients, on a pilot program basis. This paragraph
1272 (37) shall be contingent upon continued receipt of special funds
1273 from the Health Care Financing Authority and private foundations
1274 who have granted funds for planning these services. No funding
1275 for these services shall be provided from State General Funds.

1276 (38) Chiropractic services: a chiropractor's manual
1277 manipulation of the spine to correct a subluxation, if x-ray
1278 demonstrates that a subluxation exists and if the subluxation has
1279 resulted in a neuromusculoskeletal condition for which
1280 manipulation is appropriate treatment. Reimbursement for
1281 chiropractic services shall not exceed Seven Hundred Dollars
1282 ($700.00) per year per recipient.

1283 (39) The Division of Medicaid may apply for waivers from the
1284 Department of Health and Human Services to demonstrate
1285 cost-effectiveness, quality of care and services not normally
1286 provided under the state plan.

1287 Notwithstanding any provision of this article, except as

1288 authorized in the following paragraph and in Section 43-13-139,
1289 neither (a) the limitations on quantity or frequency of use of or
1290 the fees or charges for any of the care or services available to
1291 recipients under this section, nor (b) the payments or rates of
1292 reimbursement to providers rendering care or services authorized
1293 under this section to recipients, may be increased, decreased or
1294 otherwise changed from the levels in effect on July 1, 1999,
1295 unless such is authorized by an amendment to this section by the
1296 Legislature. However, the restriction in this paragraph shall not
1297 prevent the division from changing the payments or rates of
1298 reimbursement to providers without an amendment to this section
1299 whenever such changes are required by federal law or regulation,
1300 or whenever such changes are necessary to correct administrative
1301 errors or omissions in calculating such payments or rates of
1302 reimbursement.
1303 Notwithstanding any provision of this article, no new groups
1304 or categories of recipients and new types of care and services may
1305 be added without enabling legislation from the Mississippi
1306 Legislature, except that the division may authorize such changes
1307 without enabling legislation when such addition of recipients or
1308 services is ordered by a court of proper authority. The director
1309 shall keep the Governor advised on a timely basis of the funds
1310 available for expenditure and the projected expenditures. In the
1311 event current or projected expenditures can be reasonably
1312 anticipated to exceed the amounts appropriated for any fiscal
1313 year, the Governor, after consultation with the director, shall
1314 discontinue any or all of the payment of the types of care and
1315 services as provided herein which are deemed to be optional
1316 services under Title XIX of the federal Social Security Act, as
1317 amended, for any period necessary to not exceed appropriated
1318 funds, and when necessary shall institute any other cost
1319 containment measures on any program or programs authorized under
1320 the article to the extent allowed under the federal law governing
1321 such program or programs, it being the intent of the Legislature

1322 that expenditures during any fiscal year shall not exceed the
1323 amounts appropriated for such fiscal year.
1324 SECTION 8. Section 43-13-121, Mississippi Code of 1972, is
1325 amended as follows:
1326 43-13-121. (1) The division is authorized and empowered to
1327 administer a program of medical assistance under the provisions of
1328 this article, and to do the following:
1329 (a) Adopt and promulgate reasonable rules, regulations
1330 and standards, with approval of the Governor:
1331 (i) Establishing methods and procedures as may be
1332 necessary for the proper and efficient administration of this
1333 article;
1334 (ii) Providing medical assistance to all qualified
1335 recipients under the provisions of this article as the division
1336 may determine and within the limits of appropriated funds;
1337 (iii) Establishing reasonable fees, charges and
1338 rates for medical services and drugs; and in doing so shall fix
1339 all such fees, charges and rates at the minimum levels absolutely
1340 necessary to provide the medical assistance authorized by this
1341 article, and shall not change any such fees, charges or rates
1342 except as may be authorized in Section 43-13-117;
1343 (iv) Providing for fair and impartial hearings;
1344 (v) Providing safeguards for preserving the
1345 confidentiality of records; and
1346 (vi) For detecting and processing fraudulent
1347 practices and abuses of the program;
1348 (b) Receive and expend state, federal and other funds
1349 in accordance with court judgments or settlements and agreements
1350 between the State of Mississippi and the federal government, the
1351 rules and regulations promulgated by the division, with the
1352 approval of the Governor, and within the limitations and
1353 restrictions of this article and within the limits of funds
1354 available for such purpose;
1355 (c) Subject to the limits imposed by this article, to

1356 submit a plan for medical assistance to the federal Department of
1357 Health and Human Services for approval pursuant to the provisions
1358 of the Social Security Act, to act for the state in making
1359 negotiations relative to the submission and approval of such plan,
1360 to make such arrangements, not inconsistent with the law, as may
1361 be required by or pursuant to federal law to obtain and retain
1362 such approval and to secure for the state the benefits of the
1363 provisions of such law;

1364 No agreements, specifically including the general plan
1365 for the operation of the Medicaid program in this state, shall be
1366 made by and between the division and the Department of Health and
1367 Human Services unless the Attorney General of the State of
1368 Mississippi has reviewed said agreements, specifically including
1369 said operational plan, and has certified in writing to the
1370 Governor and to the director of the division that said agreements,
1371 including said plan of operation, have been drawn strictly in
1372 accordance with the terms and requirements of this article;

1373 (d) Pursuant to the purposes and intent of this article
1374 and in compliance with its provisions, provide for aged persons
1375 otherwise eligible <u>for</u> the benefits provided under Title XVIII of
1376 the federal Social Security Act by expenditure of funds available
1377 for such purposes;

1378 (e) To make reports to the federal Department of Health
1379 and Human Services as from time to time may be required by such
1380 federal department and to the Mississippi Legislature as
1381 hereinafter provided;

1382 (f) Define and determine the scope, duration and amount
1383 of medical assistance which may be provided in accordance with
1384 this article and establish priorities therefor in conformity with
1385 this article;

1386 (g) Cooperate and contract with other state agencies
1387 for the purpose of coordinating medical assistance rendered under
1388 this article and eliminating duplication and inefficiency in the
1389 program;

1390 (h) Adopt and use an official seal of the division;
1391 (i) Sue in its own name on behalf of the State of
1392 Mississippi and employ legal counsel on a contingency basis with
1393 the approval of the Attorney General;
1394 (j) To recover any and all payments incorrectly made by
1395 the division or by the Medicaid Commission to a recipient or
1396 provider from the recipient or provider receiving said payments;
1397 (k) To recover any and all payments by the division or
1398 by the Medicaid Commission fraudulently obtained by a recipient or
1399 provider. Additionally, if recovery of any payments fraudulently
1400 obtained by a recipient or provider is made in any court, then,
1401 upon motion of the Governor, the judge of said court may award
1402 twice the payments recovered as damages;
1403 (l) Have full, complete and plenary power and authority
1404 to conduct such investigations as it may deem necessary and
1405 requisite of alleged or suspected violations or abuses of the
1406 provisions of this article or of the regulations adopted hereunder
1407 including, but not limited to, fraudulent or unlawful act or deed
1408 by applicants for medical assistance or other benefits, or
1409 payments made to any person, firm or corporation under the terms,
1410 conditions and authority of this article, to suspend or disqualify
1411 any provider of services, applicant or recipient for gross abuse,
1412 fraudulent or unlawful acts for such periods, including
1413 permanently, and under such conditions as the division may deem
1414 proper and just, including the imposition of a legal rate of
1415 interest on the amount improperly or incorrectly paid. Should an
1416 administrative hearing become necessary, the division shall be
1417 authorized, should the provider not succeed in his defense, in
1418 taxing the costs of the administrative hearing, including the
1419 costs of the court reporter or stenographer and transcript, to the
1420 provider. The convictions of a recipient or a provider in a state
1421 or federal court for abuse, fraudulent or unlawful acts under this
1422 chapter shall constitute an automatic disqualification of the
1423 recipient or automatic disqualification of the provider from

1424 participation under the Medicaid program.
1425 A conviction, for the purposes of this chapter, shall
1426 include a judgment entered on a plea of nolo contendere or a
1427 nonadjudicated guilty plea and shall have the same force as a
1428 judgment entered pursuant to a guilty plea or a conviction
1429 following trial. A certified copy of the judgment of the court of
1430 competent jurisdiction of such conviction shall constitute prima
1431 facie evidence of such conviction for disqualification purposes.
1432 (m) Establish and provide such methods of
1433 administration as may be necessary for the proper and efficient
1434 operation of the program, fully utilizing computer equipment as
1435 may be necessary to oversee and control all current expenditures
1436 for purposes of this article, and to closely monitor and supervise
1437 all recipient payments and vendors rendering such services
1438 hereunder; and
1439 (n) To cooperate and contract with the federal
1440 government for the purpose of providing medical assistance to
1441 Vietnamese and Cambodian refugees, pursuant to the provisions of
1442 Public Law 94-23 and Public Law 94-24, including any amendments
1443 thereto, only to the extent that such assistance and the
1444 administrative cost related thereto are one hundred percent (100%)
1445 reimbursable by the federal government. For the purposes of
1446 Section 43-13-117, persons receiving medical assistance pursuant
1447 to Public Law 94-23 and Public Law 94-24, including any amendments
1448 thereto, shall not be considered a new group or category of
1449 recipient.
1450 (2) The division also shall exercise such additional powers
1451 and perform such other duties as may be conferred upon the
1452 division by act of the Legislature hereafter.
1453 (3) The division, and the State Department of Health as the
1454 agency for licensure of health care facilities and certification
1455 and inspection for the Medicaid and/or Medicare programs, shall
1456 contract for or otherwise provide for the consolidation of on-site
1457 inspections of health care facilities which are necessitated by

1458 the respective programs and functions of the division and the
1459 department.
1460 (4) The division and its hearing officers shall have power
1461 to preserve and enforce order during hearings; to issue subpoenas
1462 for, to administer oaths to and to compel the attendance and
1463 testimony of witnesses, or the production of books, papers,
1464 documents and other evidence, or the taking of depositions before
1465 any designated individual competent to administer oaths; to
1466 examine witnesses; and to do all things conformable to law which
1467 may be necessary to enable them effectively to discharge the
1468 duties of their office. In compelling the attendance and
1469 testimony of witnesses, or the production of books, papers,
1470 documents and other evidence, or the taking of depositions, as
1471 authorized by this section, the division or its hearing officers
1472 may designate an individual employed by the division or some other
1473 suitable person to execute and return such process, whose action
1474 in executing and returning such process shall be as lawful as if
1475 done by the sheriff or some other proper officer authorized to
1476 execute and return process in the county where the witness may
1477 reside. In carrying out the investigatory powers under the
1478 provisions of this article, the director or other designated
1479 person or persons shall be authorized to examine, obtain, copy or
1480 reproduce the books, papers, documents, medical charts,
1481 prescriptions and other records relating to medical care and
1482 services furnished by said provider to a recipient or designated
1483 recipients of Medicaid services under investigation. In the
1484 absence of the voluntary submission of said books, papers,
1485 documents, medical charts, prescriptions and other records, the
1486 Governor, the director, or other designated person shall be
1487 authorized to issue and serve subpoenas instantly upon such
1488 provider, his agent, servant or employee for the production of
1489 said books, papers, documents, medical charts, prescriptions or
1490 other records during an audit or investigation of said provider.
1491 If any provider or his agent, servant or employee should refuse to

1492 produce said records after being duly subpoenaed, the director
1493 shall be authorized to certify such facts and institute contempt
1494 proceedings in the manner, time, and place as authorized by law
1495 for administrative proceedings. As an additional remedy, the
1496 division shall be authorized to recover all amounts paid to said
1497 provider covering the period of the audit or investigation,
1498 inclusive of a legal rate of interest and a reasonable attorney's
1499 fee and costs of court if suit becomes necessary. Division staff
1500 shall have immediate access to the provider's physical location,
1501 facilities, records, documents, books, and any other records
1502 relating to medical care and services rendered to recipients
1503 during regular business hours and all other hours when employees
1504 of the provider are available and conducting the business of the
1505 provider.
1506 (5) If any person in proceedings before the division
1507 disobeys or resists any lawful order or process, or misbehaves
1508 during a hearing or so near the place thereof as to obstruct the
1509 same, or neglects to produce, after having been ordered to do so,
1510 any pertinent book, paper or document, or refuses to appear after
1511 having been subpoenaed, or upon appearing refuses to take the oath
1512 as a witness, or after having taken the oath refuses to be
1513 examined according to law, the director shall certify the facts to
1514 any court having jurisdiction in the place in which it is sitting,
1515 and the court shall thereupon, in a summary manner, hear the
1516 evidence as to the acts complained of, and if the evidence so
1517 warrants, punish such person in the same manner and to the same
1518 extent as for a contempt committed before the court, or commit
1519 such person upon the same condition as if the doing of the
1520 forbidden act had occurred with reference to the process of, or in
1521 the presence of, the court.
1522 (6) In suspending or terminating any provider from
1523 participation in the Medicaid program, the division shall preclude
1524 such provider from submitting claims for payment, either
1525 personally or through any clinic, group, corporation or other

1526 association to the division or its fiscal agents for any services
1527 or supplies provided under the Medicaid program except for those
1528 services or supplies provided prior to the suspension or
1529 termination. No clinic, group, corporation or other association
1530 which is a provider of services shall submit claims for payment to
1531 the division or its fiscal agents for any services or supplies
1532 provided by a person within such organization who has been
1533 suspended or terminated from participation in the Medicaid program
1534 except for those services or supplies provided prior to the
1535 suspension or termination. When said provision is violated by a
1536 provider of services which is a clinic, group, corporation or
1537 other association, the division may suspend or terminate such
1538 organization from participation. Suspension may be applied by the
1539 division to all known affiliates of a provider, provided that each
1540 decision to include an affiliate is made on a case by case basis
1541 after giving due regard to all relevant facts and circumstances.
1542 The violation, failure, or inadequacy of performance may be
1543 imputed to a person with whom the provider is affiliated where
1544 such conduct was accomplished with the course of his official duty
1545 or was effectuated by him with the knowledge or approval of such
1546 person.

1547 (7) If the division ascertains that a provider has been
1548 convicted of a felony under federal or state law for an offense
1549 which the division determines is detrimental to the best interests
1550 of the program or of Medicaid recipients, the division may refuse
1551 to enter into an agreement with such provider, or may terminate or
1552 refuse to renew an existing agreement.

1553 SECTION 9. Section 43-13-122, Mississippi Code of 1972, is
1554 amended as follows:

1555 43-13-122. (1) The division is authorized to apply to the
1556 Health Care Financing Administration of the U.S. Department of
1557 Health and Human Services for waivers and research and
1558 demonstration grants as are otherwise authorized by the
1559 Legislature in this chapter.

1560 * * *

1561 (2) The division is further authorized to accept and expend
1562 any grants, donations or contributions from any public or private
1563 organization together with any additional federal matching funds
1564 that may accrue and including, but not limited to, one hundred
1565 percent (100%) federal grant funds or funds from any governmental
1566 entity or instrumentality thereof in furthering the purposes and
1567 objectives of the Mississippi Medicaid program, provided that such
1568 receipts and expenditures are reported and otherwise handled in
1569 accordance with the General Fund Stabilization Act. The
1570 Department of Finance and Administration is authorized to transfer
1571 monies to the division from special funds in the State Treasury in
1572 amounts not exceeding the amounts authorized in the appropriation
1573 to the division.

1574 SECTION 10. Section 43-13-125, Mississippi Code of 1972, is
1575 amended as follows:

1576 43-13-125. (1) If medical assistance is provided to a
1577 recipient under this article for injuries, disease or sickness
1578 caused under circumstances creating a cause of action in favor of
1579 the recipient against any person, firm or corporation, then the
1580 division shall be entitled to recover the proceeds that may result
1581 from the exercise of any rights of recovery which the recipient
1582 may have against any such person, firm or corporation to the
1583 extent of the * * * Division of Medicaid's interest on behalf of
1584 the recipient. The recipient shall execute and deliver
1585 instruments and papers to do whatever is necessary to secure such
1586 rights and shall do nothing after said medical assistance is
1587 provided to prejudice the subrogation rights of the division.
1588 Court orders or agreements for reimbursement of Medicaid's
1589 interest shall direct such payments to the Division of Medicaid,
1590 which shall be authorized to endorse any and all * * *, including,
1591 but not limited to, multi-payee checks, drafts, money orders, or
1592 other negotiable instruments representing Medicaid payment
1593 recoveries that are received. In accordance with Section

1594 43-13-305, Mississippi Code of 1972, endorsement of multi-payee
1595 checks, drafts, money orders or other negotiable instruments by
1596 the Division of Medicaid shall be deemed endorsed by the
1597 recipient.

1598 The division, with the approval of the Governor, may
1599 compromise or settle any such claim and execute a release of any
1600 claim it has by virtue of this section.

1601 (2) The acceptance of medical assistance under this article
1602 or the making of a claim thereunder shall not affect the right of
1603 a recipient or his legal representative to recover Medicaid's
1604 interest as an element of special damages in any action at law;
1605 provided, however, that a copy of the pleadings shall be certified
1606 to the division at the time of the institution of suit, and proof
1607 of such notice shall be filed of record in such action. The
1608 division may, at any time before the trial on the facts, join in
1609 such action or may intervene therein. Any amount recovered by a
1610 recipient or his legal representative shall be applied as follows:

1611 (a) The reasonable costs of the collection, including
1612 attorney's fees, as approved and allowed by the court in which
1613 such action is pending, or in case of settlement without suit, by
1614 the legal representative of the division;

1615 (b) The * * * amount of Medicaid's interest on behalf
1616 of the recipient; or such pro rata amount as may be arrived at by
1617 the legal representative of the division and the recipient's
1618 attorney, or as set by the court having jurisdiction; and

1619 (c) Any excess shall be awarded to the recipient.

1620 (3) No compromise of any claim by the recipient or his legal
1621 representative shall be binding upon or affect the rights of the
1622 division against the third party unless the division, with the
1623 approval of the Governor, has entered into the compromise. Any
1624 compromise effected by the recipient or his legal representative
1625 with the third party in the absence of advance notification to and
1626 approved by the division shall constitute conclusive evidence of
1627 the liability of the third party, and the division, in litigating

1628 its claim against said third party, shall be required only to
1629 prove the amount and correctness of its claim relating to such
1630 injury, disease or sickness. It is further provided that should
1631 the recipient or his legal representative fail to notify the
1632 division of the institution of legal proceedings against a third
1633 party for which the division has a cause of action, the facts
1634 relating to negligence and the liability of the third party, if
1635 judgment is rendered for the recipient, shall constitute
1636 conclusive evidence of liability in a subsequent action maintained
1637 by the division and only the amount and correctness of the
1638 division's claim relating to injuries, disease or sickness shall
1639 be tried before the court. The division shall be authorized in
1640 bringing such action against the third party and his insurer
1641 jointly or against the insurer alone.
1642 (4) Nothing herein shall be construed to diminish or
1643 otherwise restrict the subrogation rights of the Division of
1644 Medicaid against a third party for medical assistance provided by
1645 the Division of Medicaid *** * *** to the recipient as a result of
1646 injuries, disease or sickness caused under circumstances creating
1647 a cause of action in favor of the recipient against such a third
1648 party.
1649 (5) Any amounts recovered by the division under this section
1650 shall, by the division, be placed to the credit of the funds
1651 appropriated for benefits under this article proportionate to the
1652 amounts provided by the state and federal governments
1653 respectively.
1654 SECTION 11. Section 43-13-305, Mississippi Code of 1972, is
1655 amended as follows:
1656 43-13-305. (1) By accepting Medicaid from the Division of
1657 Medicaid in the Office of the Governor, the recipient shall, to
1658 the extent of the payment of medical expenses by the Division of
1659 Medicaid, be deemed to have made an assignment to the Division of
1660 Medicaid of any and all rights and interests in any third-party
1661 benefits, hospitalization or indemnity contract or any cause of

1662 action, past, present or future, against any person, firm or
1663 corporation for Medicaid benefits provided to the recipient by the
1664 Division of Medicaid for injuries, disease or sickness caused or
1665 suffered under circumstances creating a cause of action in favor
1666 of the recipient against any such person, firm or corporation as
1667 set out in Section 43-13-125. The recipient shall be deemed,
1668 without the necessity of signing any document, to have appointed
1669 the Division of Medicaid as his or her true and lawful
1670 attorney-in-fact in his or her name, place and stead in collecting
1671 any and all amounts due and owing for medical expenses paid by the
1672 Division of Medicaid against such person, firm or corporation.
1673 (2) Whenever a provider of medical services or the Division
1674 of Medicaid submits claims to an insurer on behalf of a Medicaid
1675 recipient for whom an assignment of rights has been received, or
1676 whose rights have been assigned by the operation of law, the
1677 insurer must respond within sixty (60) days of receipt of a claim
1678 by forwarding payment or issuing a notice of denial directly to
1679 the submitter of the claim. The failure of the insuring entity to
1680 comply with the provisions of this section shall subject the
1681 insuring entity to recourse by the Division of Medicaid in
1682 accordance with the provision of Section 43-13-315. The Division
1683 of Medicaid shall be authorized to endorse any and all, including,
1684 but not limited to, multi-payee checks, drafts, money orders or
1685 other negotiable instruments representing Medicaid payment
1686 recoveries that are received by the Division of Medicaid.
1687 (3) Court orders or agreements for medical support shall
1688 direct such payments to the Division of Medicaid, which shall be
1689 authorized to endorse any and all checks, drafts, money orders or
1690 other negotiable instruments representing medical support payments
1691 which are received. Any designated medical support funds received
1692 by the State Department of Human Services or through its local
1693 county departments shall be paid over to the Division of Medicaid.
1694 When medical support for a Medicaid recipient is available through
1695 an absent parent or custodial parent, the insuring entity shall

1696 direct the medical support payment(s) to the provider of medical
1697 services or to the Division of Medicaid.
1698 SECTION 12. This act shall take effect and be in force from
1699 and after its passage.