MISSISSIPPI LEGISLATURE REGULAR SESSION 1999

By: Senator(s) Bean

To: Public Health and Welfare

SENATE BILL NO. 2143
(As Sent to Governor)

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 43-13-107,
5 MISSISSIPPI CODE OF 1972, TO CREATE A MEDICAL CARE ADVISORY
6 COMMITTEE TO THE DIVISION OF MEDICAID; TO AMEND SECTION 43-13-111,
7 MISSISSIPPI CODE OF 1972, TO CLARIFY THAT EACH STATE AGENCY SHALL
8 REQUEST AND OBTAIN AN APPROPRIATION FOR ALL MEDICAID PROGRAMS
9 ADMINISTERED BY SUCH AGENCY; TO AMEND SECTION 43-13-113,
10 MISSISSIPPI CODE OF 1972, TO REQUIRE THE DIVISION OF MEDICAID AND
11 ITS FISCAL AGENT TO IMPLEMENT A CONTINGENCY REIMBURSEMENT AND
12 ELIGIBILITY VERIFICATION PLAN IN THE EVENT OF A YEAR 2000 PROBLEM;
13 TO AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972, AS AMENDED
14 BY HOUSE BILL NO. 403, 1999 REGULAR SESSION, TO DEFINE THOSE
15 INDIVIDUALS ELIGIBLE FOR MEDICAID ASSISTANCE; TO AMEND SECTION
16 43-13-116, MISSISSIPPI CODE OF 1972, TO PROVIDE FOR LOCAL AND
17 STATE HEARING REQUESTS BY CLAIMANTS; TO AMEND SECTION 43-13-117,
18 MISSISSIPPI CODE OF 1972, AS AMENDED BY HOUSE BILL NO. 57, 1999
19 REGULAR SESSION, AND HOUSE BILL NO. 403, 1999 REGULAR SESSION, TO
20 DELETE THE REQUIREMENT FOR DIVISION OF MEDICAID APPROVAL FOR
21 REIMBURSEMENT FOR MORE THAN 15 DAYS OF INPATIENT HOSPITAL CARE, TO
22 AUTHORIZE HOSPITAL REIMBURSEMENT FOR IMPLANTABLE PROGRAMMABLE
23 PUMPS IN AN INPATIENT SETTING, TO DIRECT THE DIVISION TO DEVELOP A
24 COST-TO-CHARGE RATIO CALCULATION FOR OUTPATIENT HOSPITAL SERVICES
25 AND REPORT TO THE MEDICAL ADVISORY COMMITTEE FOR RECOMMENDATIONS
26 TO THE 2000 REGULAR SESSION, TO DELETE THE REPEALER ON THE
27 CASE-MIX REIMBURSEMENT SYSTEM FOR NURSING FACILITY SERVICES, TO
28 AUTHORIZE THE DIVISION TO REDUCE THE PAYMENT FOR HOSPITAL LEAVE
29 AND HOME LEAVE FOR A NURSING FACILITY RESIDENT USING CERTAIN
30 CASE-MIX CRITERIA AND TO AUTHORIZE THE DIVISION TO LIMIT CERTAIN
31 MANAGEMENT FEES AND HOME OFFICE COSTS FOR NURSING FACILITIES,
32 ICFMR'S AND PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES, TO
33 DELETE CERTAIN REQUIREMENTS FOR REIMBURSEMENT TO NURSING
34 FACILITIES FOR RETURN ON EQUITY CAPITAL, TO DELETE THE PROVISION
35 ESTABLISHING AND EMPOWERING THE MEDICAID REVIEW BOARD FOR NURSING
36 FACILITIES, TO AUTHORIZE A CASE-MIX REIMBURSEMENT ADD-ON AND
37 DEPRECIATION REIMBURSEMENT FOR RESIDENTS OF NURSING FACILITIES
38 WITH ALZHEIMER'S OR RELATED DEMENTIA, TO DIRECT THE DIVISION OF
39 MEDICAID TO DEVELOP AND IMPLEMENT A REFERRAL PROCESS FOR LONG-TERM
40 CARE ALTERNATIVES FOR MEDICAID BENEFICIARIES AND APPLICANTS; TO
41 PROVIDE THAT NO MEDICAID BENEFICIARY SHALL BE ADMITTED TO A
42 MEDICAID-CERTIFIED NURSING FACILITY UNLESS A LICENSED PHYSICIAN
43 CERTIFIES ON A STANDARDIZED FORM THAT NURSING FACILITY CARE IS
44 APPROPRIATE FOR THAT PERSON; TO PROVIDE THAT THE PHYSICIAN MUST
45 FORWARD A COPY OF HIS CERTIFICATION TO THE DIVISION OF MEDICAID
46 WITHIN 24 HOURS; TO REQUIRE THE DIVISION TO DETERMINE, THROUGH AN
47 ASSESSMENT OF THE APPLICANT CONDUCTED WITHIN TWO BUSINESS DAYS
48 AFTER RECEIPT OF THE PHYSICIAN'S CERTIFICATION, WHETHER THE
49 APPLICANT ALSO COULD LIVE APPROPRIATELY AND COST-EFFECTIVELY AT
50 HOME OR IN SOME OTHER COMMUNITY-BASED SETTING IF HOME- OR
51 COMMUNITY-BASED SERVICES WERE AVAILABLE TO THE APPLICANT; TO
52 PROVIDE THAT IF THE DIVISION DETERMINES THAT A HOME- OR OTHER

53 COMMUNITY-BASED SETTING IS APPROPRIATE AND COST-EFFECTIVE, IT
54 SHALL ADVISE THE APPLICANT THAT A HOME- OR OTHER COMMUNITY-BASED
55 SETTING IS APPROPRIATE AND PROVIDE A PROPOSED CARE PLAN FOR THE
56 APPLICANT; TO PROVIDE THAT THE DIVISION MAY PROVIDE THE SERVICES
57 FOR THE APPLICANT DIRECTLY OR THROUGH CONTRACT WITH CASE MANAGERS
58 FROM THE LOCAL AREA AGENCIES ON AGING; TO DELETE THE REQUIREMENT
59 THAT THE DIVISION OF MEDICAID PROVIDE HOME- AND COMMUNITY-BASED
60 SERVICES UNDER A COOPERATIVE AGREEMENT WITH THE DEPARTMENT OF
61 HUMAN SERVICES, TO INCREASE THE PHYSICIAN'S FEE AND DENTIST'S FEE
62 REIMBURSEMENT UNDER MEDICAID, TO INCREASE THE NUMBER OF MEDICAID
63 PRESCRIPTIONS UNDER CERTAIN CIRCUMSTANCES, TO AUTHORIZE THE
64 DIVISION TO REQUIRE HOME HEALTH SERVICES PROVIDERS TO OBTAIN A
65 SURETY BOND, TO AUTHORIZE THE DIVISION TO REQUIRE DURABLE MEDICAL
66 EQUIPMENT PROVIDERS TO OBTAIN A SURETY BOND AND TO DELETE THE
67 LIMITATION ON DURABLE MEDICAL EQUIPMENT REIMBURSEMENT, TO PROHIBIT
68 THE EXPANSION OF THE CAPITATED MANAGED CARE PROGRAM INTO ANY
69 COUNTY OTHER THAN CERTAIN SPECIFIED COUNTIES, TO GUARANTEE
70 MEDICAID ELIGIBILITY FOR RECIPIENTS WHO ENROLL IN THE CAPITATED
71 MANAGED CARE PROGRAM FOR NOT LESS THAN SIX MONTHS, TO AUTHORIZE
72 MEDICAID REIMBURSEMENT FOR ONE PAIR OF EYEGLASSES EVERY THREE
73 YEARS, TO DELETE THE AUTHORITY FOR THE PERSONAL CARE SERVICES
74 PILOT PROGRAM, TO DIRECT THE DIVISION TO APPLY FOR A FEDERAL
75 WAIVER TO DEVELOP A PROGRAM OF SERVICES TO PERSONAL CARE AND
76 ASSISTED LIVING HOMES, TO DELETE THE REPEALER ON THE PROVISION FOR
77 CHIROPRACTIC SERVICES REIMBURSEMENT, TO CHANGE THE DATE FOR
78 CHANGES IN REIMBURSEMENT RATES REQUIRING LEGISLATIVE APPROVAL, TO
79 DIRECT THE DIVISION TO PAY THE MEDICARE DEDUCTIBLE AND 10%
80 COINSURANCE FOR QUALIFIED MEDICAID BENEFICIARIES, AND TO PROVIDE
81 FOR MEDICAID REIMBURSEMENT FOR SERVICES PROVIDED BY THE DEPARTMENT
82 OF REHABILITATION SERVICES TO PERSONS WITH SPINAL CORD OR
83 TRAUMATIC BRAIN INJURIES, AS ALLOWED UNDER FEDERAL WAIVERS; TO
84 AMEND SECTION 43-13-121, MISSISSIPPI CODE OF 1972, TO PROVIDE FOR
85 ACCESS TO PROVIDER RECORDS FOR DIVISION STAFF AND TO DISQUALIFY
86 CERTAIN PROVIDERS FOR REIMBURSEMENT; TO AMEND SECTION 43-13-122,
87 MISSISSIPPI CODE OF 1972, IN CONFORMITY THERETO; TO AMEND SECTION
88 43-13-125, MISSISSIPPI CODE OF 1972, TO CLARIFY THAT THE DIVISION
89 OF MEDICAID'S SUBROGATION RIGHTS ARE TO THE EXTENT OF BENEFITS
90 PROVIDED BY MEDICAID ON BEHALF OF THE RECIPIENT TO WHOM THIRD
91 PARTY PAYMENTS ARE PAYABLE; TO AMEND SECTION 43-13-137,
92 MISSISSIPPI CODE OF 1972, TO DIRECT THE DIVISION OF MEDICAID TO
93 COMPLY WITH THE ADMINISTRATIVE PROCEDURES LAW; TO AMEND SECTION
94 43-13-305, MISSISSIPPI CODE OF 1972, TO AUTHORIZE THE DIVISION OF
95 MEDICAID TO ENDORSE MULTI-PAYEE CHECKS; TO AMEND SECTION
96 43-27-107, MISSISSIPPI CODE OF 1972, TO AUTHORIZE THE DEPARTMENT
97 OF HUMAN SERVICES TO CLASSIFY CERTAIN NEWLY CREATED SOCIAL WORKER
98 POSITIONS AS TIME-LIMITED EMPLOYEES; AND FOR RELATED PURPOSES.

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

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

102 43-13-103. For the purpose of affording health care and
103 remedial and institutional services in accordance with the
104 requirements for federal grants and other assistance under Titles
105 XVIII, XIX and XXI of the Social Security Act, as amended, a
106 statewide system of medical assistance is *** * *** established and
107 shall be in effect in all political subdivisions of the state, to
108 be financed by state appropriations and federal matching funds

109 therefor, and to be administered by the Office of the Governor as
110 hereinafter provided.
111 SECTION 2. Section 43-13-105, Mississippi Code of 1972, is
112 amended as follows:
113 43-13-105. When used in this article, the following
114 definitions shall apply, unless the context requires otherwise:
115 (a) "Administering agency" means the Division of
116 Medicaid in the Office of the Governor as created by this article.
117 (b) "Division" or "Division of Medicaid" means the
118 Division of Medicaid in the Office of the Governor.
119 (c) "Medical assistance" means payment of part or all
120 of the costs of medical and remedial care provided under the terms
121 of this article and in accordance with provisions of Titles XIX
122 and XXI of the Social Security Act, as amended.
123 (d) "Applicant" means a person who applies for
124 assistance under Titles IV, XVI, XIX or XXI of the Social Security
125 Act, as amended, and under the terms of this article.
126 (e) "Recipient" means a person who is eligible for
127 assistance under Title XIX or XXI of the Social Security Act, as
128 amended and under the terms of this article.
129 (f) "State health agency" shall mean any agency,
130 department, institution, board or commission of the State of
131 Mississippi, except the University Medical School, which is
132 supported in whole or in part by any public funds, including funds
133 directly appropriated from the State Treasury, funds derived by
134 taxes, fees levied or collected by statutory authority, or any
135 other funds used by "state health agencies" derived from federal
136 sources, when any funds available to such agency are expended
137 either directly or indirectly in connection with, or in support
138 of, any public health, hospital, hospitalization or other public
139 programs for the preventive treatment or actual medical treatment
140 of persons who are physically or mentally ill or mentally
141 retarded.
142 (g) "Mississippi Medicaid Commission" or "Medicaid

143 Commission" wherever they appear in the laws of the State of
144 Mississippi, shall mean the Division of Medicaid in the Office of
145 the Governor.
146 SECTION 3. Section 43-13-107, Mississippi Code of 1972, is
147 amended as follows:
148 43-13-107. (1) The Division of Medicaid is * * * created in
149 the Office of the Governor and established to administer this
150 article and perform such other duties as are prescribed by law.
151 (2) The Governor shall appoint a full-time director, with
152 the advice and consent of the Senate, who shall be either a
153 physician with administrative experience in a medical care or
154 health program or a person holding a graduate degree in medical
155 care administration, public health, hospital administration, or
156 the equivalent, and who shall serve at the will and pleasure of
157 the Governor. The director shall be the official secretary and
158 legal custodian of the records of the division; shall be the agent
159 of the division for the purpose of receiving all service of
160 process, summons and notices directed to the division; and shall
161 perform such other duties as the Governor shall, from time to
162 time, prescribe. The director, with the approval of the Governor
163 and the rules and regulations of the State Personnel Board, shall
164 employ such professional, administrative, stenographic,
165 secretarial, clerical and technical assistance as may be necessary
166 to perform the duties required in administering this article and
167 fix the compensation therefor, all in accordance with a state
168 merit system meeting federal requirements, except that when the
169 salary of the director is not set by law, such salary shall be set
170 by the State Personnel Board. No employees of the Division of
171 Medicaid shall be considered to be staff members of the immediate
172 Office of the Governor; however, the provisions of Section
173 25-9-107(xv) shall apply to the director and other administrative
174 heads of the Division.
175 (3) (a) There is established a Medical Care Advisory
176 Committee, which shall be the committee that is required by

177 federal regulation to advise the Division of Medicaid about health
178 and medical care services.
179 (b) The committee shall consist of not less than eleven
180 (11) members, as follows:
181 (i) The Governor shall appoint five (5) members,
182 one (1) from each congressional district as presently constituted;
183 (ii) The Lieutenant Governor shall appoint three
184 (3) members, one (1) from each Supreme Court district;
185 (iii) The Speaker of the House of Representatives
186 shall appoint three (3) members, one (1) from each Supreme Court
187 district;
188 All members appointed under this paragraph shall either be health
189 care providers or consumers of health care services.
190 One (1) member appointed by each of the appointing authorities
191 shall be a board certified physician.
192 (c) The respective chairmen of the House Public Health
193 and Welfare Committee, the House Appropriations Committee, the
194 Senate Public health and Welfare Committee and the Senate
195 Appropriations Committee, or their designees, one (1) member of
196 the State Senate appointed by the Lieutenant Governor and one (1)
197 member of the House of Representatives appointed by the Speaker of
198 the House, shall serve as ex officio non-voting members.
199 (d) In addition to the committee members required by
200 paragraph (b), the committee shall consist of such other members
201 as are necessary to meet the requirements of the federal
202 regulation applicable to the Medical Care Advisory Committee, who
203 shall be appointed as provided in the federal regulation.
204 (e) The chairmanship of the Medical Care Advisory
205 Committee shall alternate for twelve-month periods between the
206 chairmen of the House and Senate Public Health and Welfare
207 Committees, with the Chairman of the House Public Health and
208 Welfare Committee serving as the first chairman.
209 (f) The members of the committee specified in paragraph
210 (b) shall serve for terms that are concurrent with the terms of

211 members of the Legislature, and any member appointed under
212 paragraph (b) may be reappointed to the committee. The members of
213 the committee specified in paragraph (b) shall serve without
214 compensation, but shall receive reimbursement to defray actual
215 expenses incurred in the performance of committee business as
216 authorized by law. Legislators shall receive per diem and
217 expenses which may be paid from the contingent expense funds of
218 their respective houses in the same amounts as provided for
219 committee meetings when the Legislature is not in session.
220 (g) The committee shall meet not less than quarterly,
221 and committee members shall be furnished written notice of the
222 meetings at least ten (10) days before the date of the meeting.
223 (h) The Executive Director of the Division of Medicaid
224 shall submit to the committee all amendments, modifications and
225 changes to the state plan for the operation of the Medicaid
226 program, for review by the committee before the amendments,
227 modifications or changes may be implemented by the division.
228 (i) The committee, among its duties and
229 responsibilities, shall:
230 (i) Advise the division with respect to
231 amendments, modifications and changes to the state plan for the
232 operation of the Medicaid program;
233 (ii) Advise the division with respect to issues
234 concerning receipt and disbursement of funds and eligibility for
235 medical assistance;
236 (iii) Advise the division with respect to
237 determining the quantity, quality and extent of medical care
238 provided under this article;
239 (iv) Communicate the views of the medical care
240 professions to the division and communicate the views of the
241 division to the medical care professions;
242 (v) Gather information on reasons that medical
243 care providers do not participate in the Medicaid program and
244 changes that could be made in the program to encourage more

245 providers to participate in the Medicaid program, and advise the
246 division with respect to encouraging physicians and other medical
247 care providers to participate in the Medicaid program;
248 (vi) Provide a written report on or before
249 November 30 of each year to the Governor, Lieutenant Governor and
250 Speaker of the House of Representatives.
251 SECTION 4. Section 43-13-111, Mississippi Code of 1972, is
252 amended as follows:
253 43-13-111. Every state health agency, as defined in Section
254 43-13-105, shall obtain an appropriation of state funds from the
255 state Legislature for all medical assistance programs rendered by
256 the agency and shall organize its programs and budgets in such a
257 manner as to secure maximum federal funding through the Division
258 of Medicaid under Title XIX or Title XXI of the federal Social
259 Security Act, as amended.
260 SECTION 5. Section 43-13-113, Mississippi Code of 1972, is
261 amended as follows:
262 43-13-113. (1) The State Treasurer shall receive on behalf
263 of the state, and * * * execute all instruments incidental
264 thereto, federal and other funds to be used for financing the
265 medical assistance plan or program adopted pursuant to this
266 article, and * * * place all such funds in a special account to
267 the credit of the Governor's Office-Division of Medicaid,
268 which * * * funds shall be expended by the division for the
269 purposes and under the provisions of this article, and shall be
270 paid out by the State Treasurer as funds appropriated to carry out
271 the provisions of this article are paid out by him.
272 The division shall issue all checks or electronic transfers
273 for administrative expenses, and for medical assistance under the
274 provisions of this article. All such checks or electronic
275 transfers shall be drawn upon funds made available to the division
276 by the State Auditor, upon requisition of the director. It is the
277 purpose of this section to provide that the State Auditor shall
278 transfer, in lump sums, amounts to the division for disbursement

279 under the regulations which shall be made by the director with the
280 approval of the Governor; * * * however, * * * the division, or
281 its fiscal agent in behalf of the division, shall be authorized in
282 maintaining separate accounts with a Mississippi bank to handle
283 claim payments, refund recoveries and related Medicaid program
284 financial transactions, to aggressively manage the float in these
285 accounts while awaiting clearance of checks or electronic
286 transfers and/or other disposition so as to accrue maximum
287 interest advantage of the funds in the account, and to retain all
288 earned interest on these funds to be applied to match federal
289 funds for Medicaid program operations.

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

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

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

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

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

303 (e) If a claim is neither paid nor denied for valid and
304 proper reasons by the end of the time periods as specified above,
305 the Division of Medicaid's fiscal agent must pay the provider
306 interest on the claim at the rate of one and one-half percent
307 (1-1/2%) per month on the amount of such claim until it is finally
308 settled or adjudicated.

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

313 (4) The date of payment is the date of the check or, for
314 those claims paid by electronic funds transfer, the date of the
315 transfer.
316 (5) The above specified time limitations do not apply in the
317 following circumstances:
318 (a) Retroactive adjustments paid to providers
319 reimbursed under a retrospective payment system;
320 (b) If a claim for payment under Medicare has been
321 filed in a timely manner, the fiscal agent may pay a Medicaid
322 claim relating to the same services within six (6) months after
323 it, or the provider, receives notice of the disposition of the
324 Medicare claim;
325 (c) Claims from providers under investigation for fraud
326 or abuse; and
327 (d) The Division of Medicaid and/or its fiscal agent
328 may make payments at any time in accordance with a court order, to
329 carry out hearing decisions or corrective actions taken to resolve
330 a dispute, or to extend the benefits of a hearing decision,
331 corrective action, or court order to others in the same situation
332 as those directly affected by it.
333 (6) The Division of Medicaid and its fiscal agent shall
334 develop a contingency plan for reimbursement and eligibility
335 verification to be used in the event that on January 1, 2000, the
336 computers and computer programs used by the Division of Medicaid
337 and its fiscal agent have not been sufficiently modified to deal
338 with the issues that will result because of the year 2000. Such
339 contingency plan (a) must be ready to be implemented immediately
340 upon the realization of a year 2000 problem, (b) must be developed
341 so there will be no delay of eligibility verification or
342 reimbursement resulting from such year 2000 problem, and (c) must
343 include a periodic interim payment system for each Medicaid
344 provider that will be immediately implemented, regardless of the
345 purported effectiveness of the conversion process, should such
346 conversion process or the lack thereof result in a Medicaid

347 remittance payment to a Medicaid provider for two (2) payment
348 cycles that is less than seventy percent (70%) of the average
349 remittance to that provider during state Fiscal Year 1999. A
350 draft of the contingency plan and a summary thereof must be
351 available for review and comment by Medicaid providers no later
352 than July 1, 1999. The Medicaid providers shall be entitled to
353 submit written, substantive comments to the Division of Medicaid
354 no later than September 1, 1999, regarding such contingency plan,
355 which plan must be finalized no later than October 1, 1999,
356 whereupon the Division of Medicaid shall then make available the
357 contingency plan and a summary thereof to all Medicaid providers.
358 This subsection (6) shall stand repealed on July 1, 2001.
359 (7) If sufficient funds are appropriated therefor by the
360 Legislature, the Division of Medicaid may contract with the
361 Mississippi Dental Association, or an approved designee, to
362 develop and operate a Donated Dental Services (DDS) program
363 through which volunteer dentists will treat needy disabled, aged
364 and medically-compromised individuals who are non-Medicaid
365 eligible recipients.
366 SECTION 6. Section 43-13-115, Mississippi Code of 1972, as
367 amended by House Bill No. 403, 1999 Regular Session, is amended as
368 follows:
369 43-13-115. Recipients of medical assistance shall be the
370 following persons only:
371 (1) Who are qualified for public assistance grants under
372 provisions of Title IV-A and E of the federal Social Security Act,
373 as amended, as determined by the State Department of Human
374 Services, including those statutorily deemed to be IV-A as
375 determined by the State Department of Human Services and certified
376 to the Division of Medicaid, but not optional groups except as
377 specifically covered in this section. For the purposes of this
378 paragraph (1) and paragraphs * * * (8), * * * (17) and (18) of
379 this section, any reference to Title IV-A or to Part A of Title IV
380 of the federal Social Security Act, as amended, or the state plan

381 under Title IV-A or Part A of Title IV, shall be considered as a
382 reference to Title IV-A of the federal Social Security Act, as
383 amended, and the state plan under Title IV-A, including the income
384 and resource standards and methodologies under Title IV-A and the
385 state plan, as they existed on July 16, 1996.

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

391 (3) *** * ***

392 (4) *** * ***

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

405 (6) Children certified by the State Department of Human
406 Services to the Division of Medicaid of whom the state and county
407 human services agency has custody and financial responsibility,
408 and children who are in adoptions subsidized in full or part by
409 the Department of Human Services, who are approvable under Title
410 XIX of the Medicaid program.

411 (7) (a) Persons certified by the Division of Medicaid who
412 are patients in a medical facility (nursing home, hospital,
413 tuberculosis sanatorium or institution for treatment of mental
414 diseases), and who, except for the fact that they are patients in

415 such medical facility, would qualify for grants under Title IV,
416 supplementary security income benefits under Title XVI or state
417 supplements, and those aged, blind and disabled persons who would
418 not be eligible for supplemental security income benefits under
419 Title XVI or state supplements if they were not institutionalized
420 in a medical facility but whose income is below the maximum
421 standard set by the Division of Medicaid, which standard shall not
422 exceed that prescribed by federal regulation;

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

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

434 (9) Individuals who are:

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

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

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

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

449 (10) Certain disabled children age eighteen (18) or under
450 who are living at home, who would be eligible, if in a medical
451 institution, for SSI or a state supplemental payment under Title
452 XVI of the federal Social Security Act, as amended, and therefore
453 for Medicaid under the plan, and for whom the state has made a
454 determination as required under Section 1902(e)(3)(b) of the
455 federal Social Security Act, as amended. The eligibility of
456 individuals under this paragraph shall be determined by the
457 Division of Medicaid.
458 (11) Individuals who are sixty-five (65) years of age or
459 older or are disabled as determined under Section 1614(a)(3) of
460 the federal Social Security Act, as amended, and who meet the
461 following criteria:
462 (a) Until December 31, 1999, whose income does not
463 exceed one hundred percent (100%) of the nonfarm official poverty
464 line as defined by the Office of Management and Budget and revised
465 annually, and from and after January 1, 2000, whose income does
466 not exceed one hundred thirty-five percent (135%) of the nonfarm
467 official poverty line as defined by the Office of Management and
468 Budget and revised annually.
469 (b) Whose resources do not exceed two hundred percent
470 (200%) of the amount allowed under the Supplemental Security
471 Income (SSI) program.
472 The eligibility of individuals covered under this paragraph
473 shall be determined by the Division of Medicaid, and such
474 individuals determined eligible shall receive the same Medicaid
475 services as other categorical eligible individuals.
476 (12) Individuals who are qualified Medicare beneficiaries
477 (QMB) entitled to Part A Medicare as defined under Section 301,
478 Public Law 100-360, known as the Medicare Catastrophic Coverage
479 Act of 1988, and *** whose income does not exceed one hundred
480 percent (100%) of the nonfarm official poverty line as defined by
481 the Office of Management and Budget and revised annually.
482 ***

483 The eligibility of individuals covered under this paragraph
484 shall be determined by the Division of Medicaid, and such
485 individuals determined eligible shall receive Medicare
486 cost-sharing expenses only as more fully defined by the Medicare
487 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
488 1997.
489 (13) (a) Individuals who are entitled to Medicare Part A as
490 defined in Section 4501 of the Omnibus Budget Reconciliation Act
491 of 1990, and * * * whose income does not exceed one hundred twenty
492 percent (120%) of the nonfarm official poverty line as defined by
493 the Office of Management and Budget and revised annually * * *.
494 (b) Individuals entitled to Part A of Medicare, with
495 income above one hundred twenty percent (120%), but less than one
496 hundred thirty-five percent (135%) of the federal poverty level,
497 and not otherwise eligible for Medicaid. Eligibility for Medicaid
498 benefits is limited to full payment of Medicare Part B premiums.
499 The number of eligible individuals is limited by the availability
500 of the federal capped allocation at one hundred percent (100%) of
501 federal matching funds, as more fully defined in the Balanced
502 Budget Act of 1997.
503 (c) Individuals entitled to Part A of Medicare, with
504 income of at least one hundred thirty-five percent (135%), but not
505 exceeding one hundred seventy-five percent (175%) of the federal
506 poverty level, and not otherwise eligible for Medicaid.
507 Eligibility for Medicaid benefits is limited to partial payment of
508 Medicare Part B premiums. The number of eligible individuals is
509 limited by the availability of the federal capped allocation of
510 one hundred percent (100%) federal matching funds, as more fully
511 defined in the Balanced Budget Act of 1997.
512 The eligibility of individuals covered under this paragraph
513 shall be determined by the Division of Medicaid * * *.
514 (14) * * *
515 (15) Disabled workers who are eligible to enroll in Part A
516 Medicare as required by Public Law 101-239, known as the Omnibus

517 Budget Reconciliation Act of 1989, and whose income does not
518 exceed two hundred percent (200%) of the federal poverty level as
519 determined in accordance with the Supplemental Security Income
520 (SSI) program. The eligibility of individuals covered under this
521 paragraph shall be determined by the Division of Medicaid and such
522 individuals shall be entitled to buy-in coverage of Medicare Part
523 A premiums only under the provisions of this paragraph (15).
524 (16) In accordance with the terms and conditions of approved
525 Title XIX waiver from the United States Department of Health and
526 Human Services, persons provided home- and community-based
527 services who are physically disabled and certified by the Division
528 of Medicaid as eligible due to applying the income and deeming
529 requirements as if they were institutionalized.
530 (17) In accordance with the terms of the federal Personal
531 Responsibility and Work Opportunity Reconciliation Act of 1996
532 (Public Law 104-193), persons who become ineligible for assistance
533 under Title IV-A of the federal Social Security Act, as amended,
534 because of increased income from or hours of employment of the
535 caretaker relative or because of the expiration of the applicable
536 earned income disregards, who were eligible for Medicaid for at
537 least three (3) of the six (6) months preceding the month in which
538 such ineligibility begins, shall be eligible for Medicaid
539 assistance for up to twenty-four (24) months; however, Medicaid
540 assistance for more than twelve (12) months may be provided only
541 if a federal waiver is obtained to provide such assistance for
542 more than twelve (12) months and federal and state funds are
543 available to provide such assistance.
544 (18) Persons who become ineligible for assistance under
545 Title IV-A of the federal Social Security Act, as amended, as a
546 result, in whole or in part, of the collection or increased
547 collection of child or spousal support under Title IV-D of the
548 federal Social Security Act, as amended, who were eligible for
549 Medicaid for at least three (3) of the six (6) months immediately
550 preceding the month in which such ineligibility begins, shall be

551 eligible for Medicaid for an additional four (4) months beginning
552 with the month in which such ineligibility begins.

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

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

563 SECTION 7. Section 43-13-116, Mississippi Code of 1972, is
564 amended as follows:

565 43-13-116. (1) It shall be the duty of the Division of
566 Medicaid to fully implement and carry out the administrative
567 functions of determining the eligibility of those persons who
568 qualify for medical assistance under Section 43-13-115.

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

580 (3) Administrative hearings shall be available to any
581 applicant who requests it because his or her claim of eligibility
582 for services is denied or is not acted upon with reasonable
583 promptness or by any recipient who requests it because he or she
584 believes the agency has erroneously taken action to deny, reduce,

585 or terminate benefits. The agency need not grant a hearing if the
586 sole issue is a federal or state law requiring an automatic change
587 adversely affecting some or all recipients. Eligibility
588 determinations that are made by other agencies and certified to
589 the Division of Medicaid pursuant to Section 43-13-115 are not
590 subject to the administrative hearing procedures of the Division
591 of Medicaid but are subject to the administrative hearing
592 procedures of the agency that determined eligibility.
593 (a) A request may be made either for a local regional
594 office hearing or a state office hearing when the local regional
595 office has made the initial decision that the claimant seeks to
596 appeal or when the regional office has not acted with reasonable
597 promptness in making a decision on a claim for eligibility or
598 services. The only exception to requesting a local hearing is
599 when the issue under appeal involves either (i) a disability or
600 blindness denial, or termination, or (ii) a level of care denial
601 or termination for a disabled child living at home. An appeal
602 involving disability, blindness or level of care must be handled
603 as a state level hearing. The decision from the local hearing may
604 be appealed to the state office for a state hearing. A decision
605 to deny, reduce or terminate benefits that is initially made at
606 the state office may be appealed by requesting a state hearing.
607 (b) A request for a hearing, either state or local,
608 must be made in writing by the claimant or claimant's legal
609 representative. "Legal representative" includes the claimant's
610 authorized representative, an attorney retained by the claimant or
611 claimant's family to represent the claimant, a paralegal
612 representative with a legal aid services, a parent of a minor
613 child if the claimant is a child, a legal guardian or conservator
614 or an individual with power of attorney for the claimant. The
615 claimant may also be represented by anyone that he or she so
616 designates but must give the designation to the Medicaid regional
617 office or state office in writing, if the person is not the legal
618 representative, legal guardian, or authorized representative.

619 (c) The claimant may make a request for a hearing in
620 person at the regional office but an oral request must be put into
621 written form. Regional office staff will determine from the
622 claimant if a local or state hearing is requested and assist the
623 claimant in completing and signing the appropriate form. Regional
624 office staff may forward a state hearing request to the
625 appropriate division in the state office or the claimant may mail
626 the form to the address listed on the form. The claimant may make
627 a written request for a hearing by letter. A simple statement
628 requesting a hearing that is signed by the claimant or legal
629 representative is sufficient; however, if possible, the claimant
630 should state the reason for the request. The letter may be mailed
631 to the regional office or it may be mailed to the state office. If
632 the letter does not specify the type of hearing desired, local or
633 state, Medicaid staff will attempt to contact the claimant to
634 determine the level of hearing desired. If contact cannot be made
635 within three (3) days of receipt of the request, the request will
636 be assumed to be for a local hearing and scheduled accordingly. A
637 hearing will not be scheduled until either a letter or the
638 appropriate form is received by the regional or state office.
639 (d) When both members of a couple wish to appeal an
640 action or inaction by the agency that affects both applications or
641 cases similarly and arose from the same issue, one or both may
642 file the request for hearing, both may present evidence at the
643 hearing, and the agency's decision will be applicable to both. If
644 both file a request for hearing, two (2) hearings will be
645 registered but they will be conducted on the same day and in the
646 same place, either consecutively or jointly, as the couple wishes.
647 If they so desire, only one of the couple need attend the hearing.
648 (e) The procedure for administrative hearings shall be
649 as follows:
650 (i) The claimant has thirty (30) days from the
651 date the agency mails the appropriate notice to the claimant of
652 its decision regarding eligibility, services, or benefits to

653 request either a state or local hearing. This time period may be
654 extended if the claimant can show good cause for not filing within
655 thirty (30) days. Good cause includes, but may not be limited to,
656 illness, failure to receive the notice, being out of state, or
657 some other reasonable explanation. If good cause can be shown, a
658 late request may be accepted provided the facts in the case remain
659 the same. If a claimant's circumstances have changed or if good
660 cause for filing a request beyond thirty (30) days is not shown, a
661 hearing request will not be accepted. If the claimant wishes to
662 have eligibility reconsidered, he or she may reapply.
663 (ii) If a claimant or representative requests a
664 hearing in writing during the advance notice period before
665 benefits are reduced or terminated, benefits must be continued or
666 reinstated to the benefit level in effect before the effective
667 date of the adverse action. Benefits will continue at the
668 original level until the final hearing decision is rendered. Any
669 hearing requested after the advance notice period will not be
670 accepted as a timely request in order for continuation of benefits
671 to apply.
672 (iii) Upon receipt of a written request for a
673 hearing, the request will be acknowledged in writing within twenty
674 (20) days and a hearing scheduled. The claimant or representative
675 will be given at least five (5) days' advance notice of the
676 hearing date. <u>The local and/or state level hearings will be held</u>
677 <u>by telephone unless, at the hearing officer's discretion, it is</u>
678 <u>determined that an in-person hearing is necessary.</u> If a local
679 hearing is requested, the regional office will notify the claimant
680 or representative in writing of the time * * * of the local
681 hearing. If a state hearing is requested, the state office will
682 notify the claimant or representative in writing of the time * * *
683 of the state hearing. <u>If an in-person hearing is necessary</u>, local
684 hearings will be held at the regional office and state hearings
685 will be held at the state office unless other arrangements are
686 necessitated by the claimant's inability to travel.

687 (iv) All persons attending a hearing will attend
688 for the purpose of giving information on behalf of the claimant or
689 rendering the claimant assistance in some other way, or for the
690 purpose of representing the Division of Medicaid.
691 (v) A state or local hearing request may be
692 withdrawn at any time before the scheduled hearing, or after the
693 hearing is held but before a decision is rendered. The withdrawal
694 must be in writing and signed by the claimant or representative.
695 A hearing request will be considered abandoned if the claimant or
696 representative fails to appear at a scheduled hearing without good
697 cause. If no one appears for a hearing, the appropriate office
698 will notify the claimant in writing that the hearing is dismissed
699 unless good cause is shown for not attending. The proposed agency
700 action will be taken on the case following failure to appear for a
701 hearing if the action has not already been effected.
702 (vi) The claimant or his representative has the
703 following rights in connection with a local or state hearing:
704 (A) The right to examine at a reasonable time
705 before the date of the hearing and during the hearing the content
706 of the claimant's case record;
707 (B) The right to have legal representation at
708 the hearing and to bring witnesses;
709 (C) The right to produce documentary evidence
710 and establish all facts and circumstances concerning eligibility,
711 services, or benefits;
712 (D) The right to present an argument without
713 undue interference;
714 (E) The right to question or refute any
715 testimony or evidence including an opportunity to confront and
716 cross-examine adverse witnesses.
717 (vii) When a request for a local hearing is
718 received by the regional office or if the regional office is
719 notified by the state office that a local hearing has been
720 requested, the Medicaid specialist supervisor in the regional

721 office will review the case record, reexamine the action taken on
722 the case, and determine if policy and procedures have been
723 followed. If any adjustments or corrections should be made, the
724 Medicaid specialist supervisor will ensure that corrective action
725 is taken. If the request for hearing was timely made such that
726 continuation of benefits applies, the Medicaid specialist
727 supervisor will ensure that benefits continue at the level before
728 the proposed adverse action that is the subject of the appeal.
729 The Medicaid specialist supervisor will also ensure that all
730 needed information, verification, and evidence is in the case
731 record for the hearing.
732 (viii) When a state hearing is requested that
733 appeals the action or inaction of a regional office, the regional
734 office will prepare copies of the case record and forward it to
735 the appropriate division in the state office no later than five
736 (5) days after receipt of the request for a state hearing. The
737 original case record will remain in the regional office. Either
738 the original case record in the regional office or the copy
739 forwarded to the state office will be available for inspection by
740 the claimant or claimant's representative a reasonable time before
741 the date of the hearing.
742 (ix) The Medicaid specialist supervisor will serve
743 as the hearing officer for a local hearing unless the Medicaid
744 specialist supervisor actually participated in the eligibility,
745 benefits, or services decision under appeal, in which case the
746 Medicaid specialist supervisor must appoint a Medicaid specialist
747 in the regional office who did not actually participate in the
748 decision under appeal to serve as hearing officer. The local
749 hearing will be an informal proceeding in which the claimant or
750 representative may present new or additional information, may
751 question the action taken on the client's case, and will hear an
752 explanation from agency staff as to the regulations and
753 requirements that were applied to claimant's case in making the
754 decision.

755 (x) After the hearing, the hearing officer will
756 prepare a written summary of the hearing procedure and file it
757 with the case record. The hearing officer will consider the facts
758 presented at the local hearing in reaching a decision. The
759 claimant will be notified of the local hearing decision on the
760 appropriate form that will state clearly the reason for the
761 decision, the policy that governs the decision, the claimant's
762 right to appeal the decision to the state office, and, if the
763 original adverse action is upheld, the new effective date of the
764 reduction or termination of benefits or services if continuation
765 of benefits applied during the hearing process. The new effective
766 date of the reduction or termination of benefits or services must
767 be at the end of the fifteen-day advance notice period from the
768 mailing date of the notice of hearing decision. The notice to
769 claimant will be made part of the case record.
770 (xi) The claimant has the right to appeal a local
771 hearing decision by requesting a state hearing in writing within
772 fifteen (15) days of the mailing date of the notice of local
773 hearing decision. The state hearing request should be made to the
774 regional office. If benefits have been continued pending the
775 local hearing process, then benefits will continue throughout the
776 fifteen-day advance notice period for an adverse local hearing
777 decision. If a state hearing is timely requested within the
778 fifteen-day period, then benefits will continue pending the state
779 hearing process. State hearings requested after the fifteen-day
780 local hearing advance notice period will not be accepted unless
781 the initial thirty-day period for filing a hearing request has not
782 expired because the local hearing was held early, in which case a
783 state hearing request will be accepted as timely within the number
784 of days remaining of the unexpired initial thirty-day period in
785 addition to the fifteen-day time period. Continuation of benefits
786 during the state hearing process, however, will only apply if the
787 state hearing request is received within the fifteen-day advance
788 notice period.

789 (xii) When a request for a state hearing is
790 received in the regional office, the request will be made part of
791 the case record and the regional office will prepare the case
792 record and forward it to the appropriate division in the state
793 office within five (5) days of receipt of the state hearing
794 request. A request for a state hearing received in the state
795 office will be forwarded to the regional office for inclusion in
796 the case record and the regional office will prepare the case
797 record and forward it to the appropriate division in the state
798 office within five (5) days of receipt of the state hearing
799 request.
800 (xiii) Upon receipt of the hearing record, an
801 impartial hearing officer will be assigned to hear the case either
802 by the Executive Director of the Division of Medicaid or his or
803 her designee. Hearing officers will be individuals with
804 appropriate expertise employed by the division and who have not
805 been involved in any way with the action or decision on appeal in
806 the case. The hearing officer will review the case record and if
807 the review shows that an error was made in the action of the
808 agency or in the interpretation of policy, or that a change of
809 policy has been made, the hearing officer will discuss these
810 matters with the appropriate agency personnel and request that an
811 appropriate adjustment be made. Appropriate agency personnel will
812 discuss the matter with the claimant and if the claimant is
813 agreeable to the adjustment of the claim, then agency personnel
814 will request in writing dismissal of the hearing and the reason
815 therefor, to be placed in the case record. If the hearing is to
816 go forward, it shall be scheduled by the hearing officer in the
817 manner set forth in subparagraph (iii) of this paragraph (e).
818 (xiv) In conducting the hearing, the state hearing
819 officer will inform those present of the following:
820 (A) That the hearing will be recorded on tape
821 and that a transcript of the proceedings will be typed for the
822 record;

823 (B) The action taken by the agency which
824 prompted the appeal;
825 (C) An explanation of the claimant's rights
826 during the hearing as outlined in subparagraph (vi) of this
827 paragraph (e);
828 (D) That the purpose of the hearing is for
829 the claimant to express dissatisfaction and present additional
830 information or evidence;
831 (E) That the case record is available for
832 review by the claimant or representative during the hearing;
833 (F) That the final hearing decision will be
834 rendered by the Executive Director of the Division of Medicaid on
835 the basis of facts presented at the hearing and the case record
836 and that the claimant will be notified by letter of the final
837 decision.
838 (xv) During the hearing, the claimant and/or
839 representative will be allowed an opportunity to make a full
840 statement concerning the appeal and will be assisted, if
841 necessary, in disclosing all information on which the claim is
842 based. All persons representing the claimant and those
843 representing the Division of Medicaid will have the opportunity to
844 state all facts pertinent to the appeal. The hearing officer may
845 recess or continue the hearing for a reasonable time should
846 additional information or facts be required or if some change in
847 the claimant's circumstances occurs during the hearing process
848 which impacts the appeal. When all information has been
849 presented, the hearing officer will close the hearing and stop the
850 recorder.
851 (xvi) Immediately following the hearing the
852 hearing tape will be transcribed and a copy of the transcription
853 forwarded to the regional office for filing in the case record.
854 As soon as possible, the hearing officer shall review the evidence
855 and record of the proceedings, testimony, exhibits, and other
856 supporting documents, prepare a written summary of the facts as

857 the hearing officer finds them, and prepare a written
858 recommendation of action to be taken by the agency, citing
859 appropriate policy and regulations that govern the recommendation.
860 The decision cannot be based on any material, oral or written, not
861 available to the claimant before or during the hearing. The
862 hearing officer's recommendation will become part of the case
863 record which will be submitted to the Executive Director of the
864 Division of Medicaid for further review and decision.

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

885 (xviii) The Division of Medicaid must take final
886 administrative action on a hearing, whether state or local, within
887 ninety (90) days from the date of the initial request for a
888 hearing.

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

891 (A) The Division of Medicaid may consolidate
892 the cases and conduct a single group hearing when the only issue
893 involved is one (1) of a single law or agency policy;
894 (B) The claimants may request a group hearing
895 when there is one (1) issue of agency policy common to all of
896 them.
897 In all group hearings, whether initiated by the Division of
898 Medicaid or by the claimants, the policies governing fair hearings
899 must be followed. Each claimant in a group hearing must be
900 permitted to present his or her own case and be represented by his
901 or her own representative, or to withdraw from the group hearing
902 and have his or her appeal heard individually. As in individual
903 hearings, the hearing will be conducted only on the issue being
904 appealed, and each claimant will be expected to keep individual
905 testimony within a reasonable time frame as a matter of
906 consideration to the other claimants involved.
907 (xx) Any specific matter necessitating an
908 administrative hearing not otherwise provided under this article
909 or agency policy shall be afforded under the hearing procedures as
910 outlined above. If the specific time frames of such a unique
911 matter relating to requesting, granting, and concluding of the
912 hearing is contrary to the time frames as set out in the hearing
913 procedures above, the specific time frames will govern over the
914 time frames as set out within these procedures.
915 (4) The Executive Director of the Division of Medicaid, with
916 the approval of the Governor, shall be authorized to employ
917 eligibility, technical, clerical and supportive staff as may be
918 required in carrying out and fully implementing the determination
919 of Medicaid eligibility, including conducting quality control
920 reviews and the investigation of the improper receipt of medical
921 assistance. Staffing needs will be set forth in the annual
922 appropriation act for the division. Additional office space as
923 needed in performing eligibility, quality control and
924 investigative functions shall be obtained by the division.

925 SECTION 8. Section 43-13-117, Mississippi Code of 1972, as
926 amended by House Bill No. 57, 1999 Regular Session, and House Bill
927 No. 403, 1999 Regular Session, is amended as follows:
928 43-13-117. Medical assistance as authorized by this article
929 shall include payment of part or all of the costs, at the
930 discretion of the division or its successor, with approval of the
931 Governor, of the following types of care and services rendered to
932 eligible applicants who shall have been determined to be eligible
933 for such care and services, within the limits of state
934 appropriations and federal matching funds:
935 (1) Inpatient hospital services.
936 (a) The division shall allow thirty (30) days of
937 inpatient hospital care annually for all Medicaid
938 recipients * * *. The division shall be authorized to allow
939 unlimited days in disproportionate hospitals as defined by the
940 division for eligible infants under the age of six (6) years.
941 (b) From and after July 1, 1994, the Executive Director
942 of the Division of Medicaid shall amend the Mississippi Title XIX
943 Inpatient Hospital Reimbursement Plan to remove the occupancy rate
944 penalty from the calculation of the Medicaid Capital Cost
945 Component utilized to determine total hospital costs allocated to
946 the Medicaid program.
947 <u>(c) Hospitals will receive an additional payment for</u>
948 <u>the implantable programmable pump for approved spasticity patients</u>
949 <u>implanted in an inpatient setting, to be determined by the</u>
950 <u>Division of Medicaid and approved by the Medical Advisory</u>
951 <u>Committee. The payment pursuant to written invoice will be in</u>
952 <u>addition to the facility's per diem reimbursement and will</u>
953 <u>represent a reduction of costs on the facility's annual cost</u>
954 <u>report, and shall not exceed Ten Thousand Dollars ($10,000.00) per</u>
955 <u>year per recipient. This paragraph (c) shall stand repealed on</u>
956 <u>July 1, 2000.</u>
957 (2) Outpatient hospital services. Provided that where the
958 same services are reimbursed as clinic services, the division may

959 revise the rate or methodology of outpatient reimbursement to
960 maintain consistency, efficiency, economy and quality of care.
961 The division shall develop a Medicaid-specific cost-to-charge
962 ratio calculation from data provided by hospitals to determine an
963 allowable rate payment for outpatient hospital services, and shall
964 submit a report thereon to the Medical Advisory Committee on or
965 before December 1, 1999. The committee shall make a
966 recommendation on the specific cost-to-charge reimbursement method
967 for outpatient hospital services to the 2000 Regular Session of
968 the Legislature.

969 (3) Laboratory and X-ray services.

970 (4) Nursing facility services.

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

987 (b) From and after July 1, 1997, the division shall
988 implement the integrated case-mix payment and quality monitoring
989 system *** * ***, which includes the fair rental system for property
990 costs and in which recapture of depreciation is eliminated. The
991 division may reduce the payment *** * *** for hospital leave and
992 therapeutic home leave days to the lower of the case-mix category

993 as computed for the resident on leave using the assessment being
994 utilized for payment at that point in time, or a case-mix score of
995 1.000 for nursing facilities, and shall compute case-mix scores of
996 residents so that only services provided at the nursing facility
997 are considered in calculating a facility's per diem * * *. * * *
998 The division is authorized to limit allowable management fees and
999 home office costs to either three percent (3%), five percent (5%)
1000 or seven percent (7%) of other allowable costs, including
1001 allowable therapy costs and property costs, based on the types of
1002 management services provided, as follows:
1003 A maximum of up to three percent (3%) shall be allowed where
1004 centralized managerial and administrative services are provided by
1005 the management company or home office.
1006 A maximum of up to five percent (5%) shall be allowed where
1007 centralized managerial and administrative services and limited
1008 professional and consultant services are provided.
1009 A maximum of up to seven percent (7%) shall be allowed where
1010 a full spectrum of centralized managerial services, administrative
1011 services, professional services and consultant services are
1012 provided.
1013 (c) From and after July 1, 1997, all state-owned
1014 nursing facilities shall be reimbursed on a full reasonable cost
1015 basis. * * *
1016 * * *
1017 (d) When a facility of a category that does not require
1018 a certificate of need for construction and that could not be
1019 eligible for Medicaid reimbursement is constructed to nursing
1020 facility specifications for licensure and certification, and the
1021 facility is subsequently converted to a nursing facility pursuant
1022 to a certificate of need that authorizes conversion only and the
1023 applicant for the certificate of need was assessed an application
1024 review fee based on capital expenditures incurred in constructing
1025 the facility, the division shall allow reimbursement for capital
1026 expenditures necessary for construction of the facility that were

1027 incurred within the twenty-four (24) consecutive calendar months
1028 immediately preceding the date that the certificate of need
1029 authorizing such conversion was issued, to the same extent that
1030 reimbursement would be allowed for construction of a new nursing
1031 facility pursuant to a certificate of need that authorizes such
1032 construction. The reimbursement authorized in this subparagraph
1033 (d) may be made only to facilities the construction of which was
1034 completed after June 30, 1989. Before the division shall be
1035 authorized to make the reimbursement authorized in this
1036 subparagraph (d), the division first must have received approval
1037 from the Health Care Financing Administration of the United States
1038 Department of Health and Human Services of the change in the state
1039 Medicaid plan providing for such reimbursement.
1040 (e) The division shall develop and implement a case-mix
1041 payment add-on determined by time studies and other valid
1042 statistical data which will reimburse a nursing facility for the
1043 additional cost of caring for a resident who has a diagnosis of
1044 Alzheimer's or other related dementia and exhibits symptoms that
1045 require special care. Any such case-mix add-on payment shall be
1046 supported by a determination of additional cost. The division
1047 shall also develop and implement as part of the fair rental
1048 reimbursement system for nursing facility beds, an Alzheimer's
1049 resident bed depreciation enhanced reimbursement system which will
1050 provide an incentive to encourage nursing facilities to convert or
1051 construct beds for residents with Alzheimer's or other related
1052 dementia.
1053 (f) The Division of Medicaid shall develop and
1054 implement a referral process for long-term care alternatives for
1055 Medicaid beneficiaries and applicants. No Medicaid beneficiary
1056 shall be admitted to a Medicaid-certified nursing facility unless
1057 a licensed physician certifies that nursing facility care is
1058 appropriate for that person on a standardized form to be prepared
1059 and provided to nursing facilities by the Division of Medicaid.
1060 The physician shall forward a copy of that certification to the

1061 Division of Medicaid within twenty-four (24) hours after it is
1062 signed by the physician. Any physician who fails to forward the
1063 certification to the Division of Medicaid within the time period
1064 specified in this paragraph shall be ineligible for Medicaid
1065 reimbursement for any physician's services performed for the
1066 applicant. The Division of Medicaid shall determine, through an
1067 assessment of the applicant conducted within two (2) business days
1068 after receipt of the physician's certification, whether the
1069 applicant also could live appropriately and cost-effectively at
1070 home or in some other community-based setting if home- or
1071 community-based services were available to the applicant. The
1072 time limitation prescribed in this paragraph shall be waived in
1073 cases of emergency. If the Division of Medicaid determines that a
1074 home- or other community-based setting is appropriate and
1075 cost-effective, the division shall:
1076 (i) Advise the applicant or the applicant's legal
1077 representative that a home- or other community-based setting is
1078 appropriate;
1079 (ii) Provide a proposed care plan and inform the
1080 applicant or the applicant's legal representative regarding the
1081 degree to which the services in the care plan are available in a
1082 home- or in other community-based setting rather than nursing
1083 facility care; and
1084 (iii) Explain that such plan and services are
1085 available only if the applicant or the applicant's legal
1086 representative chooses a home- or community-based alternative to
1087 nursing facility care, and that the applicant is free to choose
1088 nursing facility care.
1089 The Division of Medicaid may provide the services described
1090 in this paragraph (f) directly or through contract with case
1091 managers from the local Area Agencies on Aging, and shall
1092 coordinate long-term care alternatives to avoid duplication with
1093 hospital discharge planning procedures.
1094 Placement in a nursing facility may not be denied by the

1095 division if home- or community-based services that would be more
1096 appropriate than nursing facility care are not actually available,
1097 or if the applicant chooses not to receive the appropriate home-
1098 or community-based services.
1099 The division shall provide an opportunity for a fair hearing
1100 under federal regulations to any applicant who is not given the
1101 choice of home- or community-based services as an alternative to
1102 institutional care.
1103 The division shall make full payment for long-term care
1104 alternative services.
1105 The division shall apply for necessary federal waivers to
1106 assure that additional services providing alternatives to nursing
1107 facility care are made available to applicants for nursing
1108 facility care.
1109 (5) Periodic screening and diagnostic services for
1110 individuals under age twenty-one (21) years as are needed to
1111 identify physical and mental defects and to provide health care
1112 treatment and other measures designed to correct or ameliorate
1113 defects and physical and mental illness and conditions discovered
1114 by the screening services regardless of whether these services are
1115 included in the state plan. The division may include in its
1116 periodic screening and diagnostic program those discretionary
1117 services authorized under the federal regulations adopted to
1118 implement Title XIX of the federal Social Security Act, as
1119 amended. The division, in obtaining physical therapy services,
1120 occupational therapy services, and services for individuals with
1121 speech, hearing and language disorders, may enter into a
1122 cooperative agreement with the State Department of Education for
1123 the provision of such services to handicapped students by public
1124 school districts using state funds which are provided from the
1125 appropriation to the Department of Education to obtain federal
1126 matching funds through the division. The division, in obtaining
1127 medical and psychological evaluations for children in the custody
1128 of the State Department of Human Services may enter into a

1129 cooperative agreement with the State Department of Human Services
1130 for the provision of such services using state funds which are
1131 provided from the appropriation to the Department of Human
1132 Services to obtain federal matching funds through the division.
1133 On July 1, 1993, all fees for periodic screening and
1134 diagnostic services under this paragraph (5) shall be increased by
1135 twenty-five percent (25%) of the reimbursement rate in effect on
1136 June 30, 1993.
1137 (6) Physician's services. * * * All fees for physicians'
1138 services that are covered only by Medicaid shall be reimbursed at
1139 ninety percent (90%) of the rate established on January 1, 1999,
1140 and as adjusted each January thereafter, under Medicare (Title
1141 XVIII of the Social Security Act, as amended), and which shall in
1142 no event be less than seventy percent (70%) of the rate
1143 established on January 1, 1994. All fees for physicians' services
1144 that are covered by both Medicare and Medicaid shall be reimbursed
1145 at ten percent (10%) of the adjusted Medicare payment established
1146 on January 1, 1999, and as adjusted each January thereafter, under
1147 Medicare (Title XVIII of the Social Security Act, as amended), and
1148 which shall in no event be less than seven percent (7%) of the
1149 adjusted Medicare payment established on January 1, 1994.
1150 (7) (a) Home health services for eligible persons, not to
1151 exceed in cost the prevailing cost of nursing facility services,
1152 not to exceed sixty (60) visits per year.
1153 (b) Repealed.
1154 (8) Emergency medical transportation services. On January
1155 1, 1994, emergency medical transportation services shall be
1156 reimbursed at seventy percent (70%) of the rate established under
1157 Medicare (Title XVIII of the Social Security Act, as amended).
1158 "Emergency medical transportation services" shall mean, but shall
1159 not be limited to, the following services by a properly permitted
1160 ambulance operated by a properly licensed provider in accordance
1161 with the Emergency Medical Services Act of 1974 (Section 41-59-1
1162 et seq.): (i) basic life support, (ii) advanced life support,

1163 (iii) mileage, (iv) oxygen, (v) intravenous fluids, (vi)
1164 disposable supplies, (vii) similar services.
1165 (9) Legend and other drugs as may be determined by the
1166 division. The division may implement a program of prior approval
1167 for drugs to the extent permitted by law. Payment by the division
1168 for covered multiple source drugs shall be limited to the lower of
1169 the upper limits established and published by the Health Care
1170 Financing Administration (HCFA) plus a dispensing fee of Four
1171 Dollars and Ninety-one Cents ($4.91), or the estimated acquisition
1172 cost (EAC) as determined by the division plus a dispensing fee of
1173 Four Dollars and Ninety-one Cents ($4.91), or the providers' usual
1174 and customary charge to the general public. The division shall
1175 allow five (5) prescriptions per month for noninstitutionalized
1176 Medicaid recipients; however, exceptions for up to ten (10)
1177 prescriptions per month shall be allowed, with the approval of the
1178 director.
1179 Payment for other covered drugs, other than multiple source
1180 drugs with HCFA upper limits, shall not exceed the lower of the
1181 estimated acquisition cost as determined by the division plus a
1182 dispensing fee of Four Dollars and Ninety-one Cents ($4.91) or the
1183 providers' usual and customary charge to the general public.
1184 Payment for nonlegend or over-the-counter drugs covered on
1185 the division's formulary shall be reimbursed at the lower of the
1186 division's estimated shelf price or the providers' usual and
1187 customary charge to the general public. No dispensing fee shall
1188 be paid.
1189 The division shall develop and implement a program of payment
1190 for additional pharmacist services, with payment to be based on
1191 demonstrated savings, but in no case shall the total payment
1192 exceed twice the amount of the dispensing fee.
1193 As used in this paragraph (9), "estimated acquisition cost"
1194 means the division's best estimate of what price providers
1195 generally are paying for a drug in the package size that providers
1196 buy most frequently. Product selection shall be made in

1197 compliance with existing state law; however, the division may
1198 reimburse as if the prescription had been filled under the generic
1199 name. The division may provide otherwise in the case of specified
1200 drugs when the consensus of competent medical advice is that
1201 trademarked drugs are substantially more effective.

1202 (10) Dental care that is an adjunct to treatment of an acute
1203 medical or surgical condition; services of oral surgeons and
1204 dentists in connection with surgery related to the jaw or any
1205 structure contiguous to the jaw or the reduction of any fracture
1206 of the jaw or any facial bone; and emergency dental extractions
1207 and treatment related thereto. On July 1, 1999, all fees for
1208 dental care and surgery under authority of this paragraph (10)
1209 shall be increased to one hundred sixty percent (160%) of the
1210 amount of the reimbursement rate that was in effect on June 30,
1211 1999. It is the intent of the Legislature to encourage more
1212 dentists to participate in the Medicaid program.

1213 (11) Eyeglasses necessitated by reason of eye surgery, and
1214 as prescribed by a physician skilled in diseases of the eye or an
1215 optometrist, whichever the patient may select, or one (1) pair
1216 every three (3) years as prescribed by a physician or an
1217 optometrist, whichever the patient may select.

1218 (12) Intermediate care facility services.

1219 (a) The division shall make full payment to all
1220 intermediate care facilities for the mentally retarded for each
1221 day, not exceeding eighty-four (84) days per year, that a patient
1222 is absent from the facility on home leave. Payment may be made
1223 for the following home leave days in addition to the 84-day
1224 limitation: Christmas, the day before Christmas, the day after
1225 Christmas, Thanksgiving, the day before Thanksgiving and the day
1226 after Thanksgiving. However, before payment may be made for more
1227 than eighteen (18) home leave days in a year for a patient, the
1228 patient must have written authorization from a physician stating
1229 that the patient is physically and mentally able to be away from
1230 the facility on home leave. Such authorization must be filed with

1231 the division before it will be effective, and the authorization
1232 shall be effective for three (3) months from the date it is
1233 received by the division, unless it is revoked earlier by the
1234 physician because of a change in the condition of the patient.
1235 (b) All state-owned intermediate care facilities for
1236 the mentally retarded shall be reimbursed on a full reasonable
1237 cost basis.
1238 (c) The division is authorized to limit allowable
1239 management fees and home office costs to either three percent
1240 (3%), five percent (5%) or seven percent (7%) of other allowable
1241 costs, including allowable therapy costs and property costs, based
1242 on the types of management services provided, as follows:
1243 A maximum of up to three percent (3%) shall be allowed where
1244 centralized managerial and administrative services are provided by
1245 the management company or home office.
1246 A maximum of up to five percent (5%) shall be allowed where
1247 centralized managerial and administrative services and limited
1248 professional and consultant services are provided.
1249 A maximum of up to seven percent (7%) shall be allowed where
1250 a full spectrum of centralized managerial services, administrative
1251 services, professional services and consultant services are
1252 provided.
1253 (13) Family planning services, including drugs, supplies and
1254 devices, when such services are under the supervision of a
1255 physician.
1256 (14) Clinic services. Such diagnostic, preventive,
1257 therapeutic, rehabilitative or palliative services furnished to an
1258 outpatient by or under the supervision of a physician or dentist
1259 in a facility which is not a part of a hospital but which is
1260 organized and operated to provide medical care to outpatients.
1261 Clinic services shall include any services reimbursed as
1262 outpatient hospital services which may be rendered in such a
1263 facility, including those that become so after July 1, 1991. On
1264 July 1, 1999, all fees for physicians' services reimbursed under

1265 authority of this paragraph (14) shall be reimbursed at ninety
1266 percent (90%) of the rate established on January 1, 1999, and as
1267 adjusted each January thereafter, under Medicare (Title XVIII of
1268 the Social Security Act, as amended), and which shall in no event
1269 be less than seventy percent (70%) of the rate established on
1270 January 1, 1994. All fees for physicians' services that are
1271 covered by both Medicare and Medicaid shall be reimbursed at ten
1272 percent (10%) of the adjusted Medicare payment established on
1273 January 1, 1999, and as adjusted each January thereafter, under
1274 Medicare (Title XVIII of the Social Security Act, as amended), and
1275 which shall in no event be less than seven percent (7%) of the
1276 adjusted Medicare payment established on January 1, 1994. On July
1277 1, 1999, all fees for dentists' services reimbursed under
1278 authority of this paragraph (14) shall be increased to one hundred
1279 sixty percent (160%) of the amount of the reimbursement rate that
1280 was in effect on June 30, 1999.
1281 (15) Home- and community-based services, as provided under
1282 Title XIX of the federal Social Security Act, as amended, under
1283 waivers, subject to the availability of funds specifically
1284 appropriated therefor by the Legislature. Payment for such
1285 services shall be limited to individuals who would be eligible for
1286 and would otherwise require the level of care provided in a
1287 nursing facility. The home- and community-based services
1288 authorized under this paragraph shall be expanded over a five-year
1289 period beginning July 1, 1999. The division shall certify case
1290 management agencies to provide case management services and
1291 provide for home- and community-based services for eligible
1292 individuals under this paragraph. The home- and community-based
1293 services under this paragraph and the activities performed by
1294 certified case management agencies under this paragraph shall be
1295 funded using state funds that are provided from the appropriation
1296 to the Division of Medicaid and used to match federal funds *** * ***.
1297 (16) Mental health services. Approved therapeutic and case
1298 management services provided by (a) an approved regional mental

1299 health/retardation center established under Sections 41-19-31
1300 through 41-19-39, or by another community mental health service
1301 provider meeting the requirements of the Department of Mental
1302 Health to be an approved mental health/retardation center if
1303 determined necessary by the Department of Mental Health, using
1304 state funds which are provided from the appropriation to the State
1305 Department of Mental Health and used to match federal funds under
1306 a cooperative agreement between the division and the department,
1307 or (b) a facility which is certified by the State Department of
1308 Mental Health to provide therapeutic and case management services,
1309 to be reimbursed on a fee for service basis. Any such services
1310 provided by a facility described in paragraph (b) must have the
1311 prior approval of the division to be reimbursable under this
1312 section. After June 30, 1997, mental health services provided by
1313 regional mental health/retardation centers established under
1314 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
1315 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
1316 psychiatric residential treatment facilities as defined in Section
1317 43-11-1, or by another community mental health service provider
1318 meeting the requirements of the Department of Mental Health to be
1319 an approved mental health/retardation center if determined
1320 necessary by the Department of Mental Health, shall not be
1321 included in or provided under any capitated managed care pilot
1322 program provided for under paragraph (24) of this section.
1323 (17) Durable medical equipment services and medical
1324 supplies *** * ***. The Division of Medicaid may require durable
1325 medical equipment providers to obtain a surety bond in the amount
1326 and to the specifications as established by the Balanced Budget
1327 Act of 1997.
1328 (18) Notwithstanding any other provision of this section to
1329 the contrary, the division shall make additional reimbursement to
1330 hospitals which serve a disproportionate share of low-income
1331 patients and which meet the federal requirements for such payments
1332 as provided in Section 1923 of the federal Social Security Act and

1333 any applicable regulations.

1334 (19) (a) Perinatal risk management services. The division
1335 shall promulgate regulations to be effective from and after
1336 October 1, 1988, to establish a comprehensive perinatal system for
1337 risk assessment of all pregnant and infant Medicaid recipients and
1338 for management, education and follow-up for those who are
1339 determined to be at risk. Services to be performed include case
1340 management, nutrition assessment/counseling, psychosocial
1341 assessment/counseling and health education. The division shall
1342 set reimbursement rates for providers in conjunction with the
1343 State Department of Health.

1344 (b) Early intervention system services. The division
1345 shall cooperate with the State Department of Health, acting as
1346 lead agency, in the development and implementation of a statewide
1347 system of delivery of early intervention services, pursuant to
1348 Part H of the Individuals with Disabilities Education Act (IDEA).
1349 The State Department of Health shall certify annually in writing
1350 to the director of the division the dollar amount of state early
1351 intervention funds available which shall be utilized as a
1352 certified match for Medicaid matching funds. Those funds then
1353 shall be used to provide expanded targeted case management
1354 services for Medicaid eligible children with special needs who are
1355 eligible for the state's early intervention system.
1356 Qualifications for persons providing service coordination shall be
1357 determined by the State Department of Health and the Division of
1358 Medicaid.

1359 (20) Home- and community-based services for physically
1360 disabled approved services as allowed by a waiver from the United
1361 States Department of Health and Human Services for home- and
1362 community-based services for physically disabled people using
1363 state funds which are provided from the appropriation to the State
1364 Department of Rehabilitation Services and used to match federal
1365 funds under a cooperative agreement between the division and the
1366 department, provided that funds for these services are

1367 specifically appropriated to the Department of Rehabilitation
1368 Services.
1369 (21) Nurse practitioner services. Services furnished by a
1370 registered nurse who is licensed and certified by the Mississippi
1371 Board of Nursing as a nurse practitioner including, but not
1372 limited to, nurse anesthetists, nurse midwives, family nurse
1373 practitioners, family planning nurse practitioners, pediatric
1374 nurse practitioners, obstetrics-gynecology nurse practitioners and
1375 neonatal nurse practitioners, under regulations adopted by the
1376 division. Reimbursement for such services shall not exceed ninety
1377 percent (90%) of the reimbursement rate for comparable services
1378 rendered by a physician.
1379 (22) Ambulatory services delivered in federally qualified
1380 health centers and in clinics of the local health departments of
1381 the State Department of Health for individuals eligible for
1382 medical assistance under this article based on reasonable costs as
1383 determined by the division.
1384 (23) Inpatient psychiatric services. Inpatient psychiatric
1385 services to be determined by the division for recipients under age
1386 twenty-one (21) which are provided under the direction of a
1387 physician in an inpatient program in a licensed acute care
1388 psychiatric facility or in a licensed psychiatric residential
1389 treatment facility, before the recipient reaches age twenty-one
1390 (21) or, if the recipient was receiving the services immediately
1391 before he reached age twenty-one (21), before the earlier of the
1392 date he no longer requires the services or the date he reaches age
1393 twenty-two (22), as provided by federal regulations. Recipients
1394 shall be allowed forty-five (45) days per year of psychiatric
1395 services provided in acute care psychiatric facilities, and shall
1396 be allowed unlimited days of psychiatric services provided in
1397 licensed psychiatric residential treatment facilities. The
1398 division is authorized to limit allowable management fees and home
1399 office costs to either three percent (3%), five percent (5%) or
1400 seven percent (7%) of other allowable costs, including allowable

1401 therapy costs and property costs, based on the types of management
1402 services provided, as follows:
1403 A maximum of up to three percent (3%) shall be allowed where
1404 centralized managerial and administrative services are provided by
1405 the management company or home office.
1406 A maximum of up to five percent (5%) shall be allowed where
1407 centralized managerial and administrative services and limited
1408 professional and consultant services are provided.
1409 A maximum of up to seven percent (7%) shall be allowed where
1410 a full spectrum of centralized managerial services, administrative
1411 services, professional services and consultant services are
1412 provided.
1413 (24) Managed care services in a program to be developed by
1414 the division by a public or private provider.
1415 (a) Notwithstanding any other provision in this article
1416 to the contrary, the division shall establish rates of
1417 reimbursement to providers rendering care and services authorized
1418 under this paragraph (24), and may revise such rates of
1419 reimbursement without amendment to this section by the Legislature
1420 for the purpose of achieving effective and accessible health
1421 services, and for responsible containment of costs.
1422 (b) The managed care services under this paragraph (24)
1423 shall include, but not be limited to, one (1) module of capitated
1424 managed care in a rural area, and one (1) module of capitated care
1425 in an urban area; however, the capitated managed care program
1426 operated by the division shall not be implemented, conducted or
1427 expanded into any county or part of any county other than the
1428 following counties: Covington, Forrest, Hancock, Harrison, Lamar,
1429 Lauderdale, Pearl River, Perry, Warren and Washington. From and
1430 after passage of this act, Medicaid eligibility is guaranteed up
1431 to six (6) months for individuals enrolled in a Medicaid managed
1432 care program. This subparagraph (b) shall stand repealed on July
1433 1, 2002.
1434 (25) Birthing center services.

1435 (26) Hospice care. As used in this paragraph, the term
1436 "hospice care" means a coordinated program of active professional
1437 medical attention within the home and outpatient and inpatient
1438 care which treats the terminally ill patient and family as a unit,
1439 employing a medically directed interdisciplinary team. The
1440 program provides relief of severe pain or other physical symptoms
1441 and supportive care to meet the special needs arising out of
1442 physical, psychological, spiritual, social and economic stresses
1443 which are experienced during the final stages of illness and
1444 during dying and bereavement and meets the Medicare requirements
1445 for participation as a hospice as provided in federal regulations.
1446 (27) Group health plan premiums and cost sharing if it is
1447 cost effective as defined by the Secretary of Health and Human
1448 Services.
1449 (28) Other health insurance premiums which are cost
1450 effective as defined by the Secretary of Health and Human
1451 Services. Medicare eligible must have Medicare Part B before
1452 other insurance premiums can be paid.
1453 (29) The Division of Medicaid may apply for a waiver from
1454 the Department of Health and Human Services for home- and
1455 community-based services for developmentally disabled people using
1456 state funds which are provided from the appropriation to the State
1457 Department of Mental Health and used to match federal funds under
1458 a cooperative agreement between the division and the department,
1459 provided that funds for these services are specifically
1460 appropriated to the Department of Mental Health.
1461 (30) Pediatric skilled nursing services for eligible persons
1462 under twenty-one (21) years of age.
1463 (31) Targeted case management services for children with
1464 special needs, under waivers from the United States Department of
1465 Health and Human Services, using state funds that are provided
1466 from the appropriation to the Mississippi Department of Human
1467 Services and used to match federal funds under a cooperative
1468 agreement between the division and the department.

1469 (32) Care and services provided in Christian Science
1470 Sanatoria operated by or listed and certified by The First Church
1471 of Christ Scientist, Boston, Massachusetts, rendered in connection
1472 with treatment by prayer or spiritual means to the extent that
1473 such services are subject to reimbursement under Section 1903 of
1474 the Social Security Act.

1475 (33) Podiatrist services.

1476 (34) <u>The division shall make application to the United</u>
1477 <u>States Health Care Financing Administration for a waiver to</u>
1478 <u>develop a program of services to personal care and assisted living</u>
1479 <u>homes in Mississippi. This waiver shall be completed by December</u>
1480 <u>1, 1999.</u>

1481 (35) Services and activities authorized in Sections
1482 43-27-101 and 43-27-103, using state funds that are provided from
1483 the appropriation to the State Department of Human Services and
1484 used to match federal funds under a cooperative agreement between
1485 the division and the department.

1486 (36) Nonemergency transportation services for
1487 Medicaid-eligible persons, to be provided by the <u>Division of</u>
1488 <u>Medicaid</u>. The division may contract with additional entities to
1489 administer nonemergency transportation services as it deems
1490 necessary. All providers shall have a valid driver's license,
1491 vehicle inspection sticker<u>, valid vehicle license tags</u> and a
1492 standard liability insurance policy covering the vehicle.

1493 (37) Targeted case management services for individuals with
1494 chronic diseases, with expanded eligibility to cover services to
1495 uninsured recipients, on a pilot program basis. This paragraph
1496 (37) shall be contingent upon continued receipt of special funds
1497 from the Health Care Financing Authority and private foundations
1498 who have granted funds for planning these services. No funding
1499 for these services shall be provided from State General Funds.

1500 (38) Chiropractic services: a chiropractor's manual
1501 manipulation of the spine to correct a subluxation, if x-ray
1502 demonstrates that a subluxation exists and if the subluxation has

1503 resulted in a neuromusculoskeletal condition for which
1504 manipulation is appropriate treatment. Reimbursement for
1505 chiropractic services shall not exceed Seven Hundred Dollars
1506 ($700.00) per year per recipient.
1507 (39) Dually eligible Medicare/Medicaid beneficiaries. The
1508 division shall pay Medicare deductible and ten percent (10%)
1509 coinsurance amounts for services available under Medicare for the
1510 duration and scope of services otherwise available under the
1511 Medicaid program.
1512 (40) The division shall prepare an application for a waiver
1513 to provide prescription drug benefits to as many Mississippians as
1514 permitted under Title XIX of the Social Security Act.
1515 (41) Services provided by the State Department of
1516 Rehabilitation Services for the care and rehabilitation of persons
1517 with spinal cord injuries or traumatic brain injuries, as allowed
1518 under waivers from the United States Department of Health and
1519 Human Services, using up to seventy-five percent (75%) of the
1520 funds that are appropriated to the Department of Rehabilitation
1521 Services from the Spinal Cord and Head Injury Trust Fund
1522 established under Section 37-33-261 and used to match federal
1523 funds under a cooperative agreement between the division and the
1524 department.
1525 Notwithstanding any provision of this article, except as
1526 authorized in the following paragraph and in Section 43-13-139,
1527 neither (a) the limitations on quantity or frequency of use of or
1528 the fees or charges for any of the care or services available to
1529 recipients under this section, nor (b) the payments or rates of
1530 reimbursement to providers rendering care or services authorized
1531 under this section to recipients, may be increased, decreased or
1532 otherwise changed from the levels in effect on July 1, 1999,
1533 unless such is authorized by an amendment to this section by the
1534 Legislature. However, the restriction in this paragraph shall not
1535 prevent the division from changing the payments or rates of
1536 reimbursement to providers without an amendment to this section

1537 whenever such changes are required by federal law or regulation,
1538 or whenever such changes are necessary to correct administrative
1539 errors or omissions in calculating such payments or rates of
1540 reimbursement.

1541 Notwithstanding any provision of this article, no new groups
1542 or categories of recipients and new types of care and services may
1543 be added without enabling legislation from the Mississippi
1544 Legislature, except that the division may authorize such changes
1545 without enabling legislation when such addition of recipients or
1546 services is ordered by a court of proper authority. The director
1547 shall keep the Governor advised on a timely basis of the funds
1548 available for expenditure and the projected expenditures. In the
1549 event current or projected expenditures can be reasonably
1550 anticipated to exceed the amounts appropriated for any fiscal
1551 year, the Governor, after consultation with the director, shall
1552 discontinue any or all of the payment of the types of care and
1553 services as provided herein which are deemed to be optional
1554 services under Title XIX of the federal Social Security Act, as
1555 amended, for any period necessary to not exceed appropriated
1556 funds, and when necessary shall institute any other cost
1557 containment measures on any program or programs authorized under
1558 the article to the extent allowed under the federal law governing
1559 such program or programs, it being the intent of the Legislature
1560 that expenditures during any fiscal year shall not exceed the
1561 amounts appropriated for such fiscal year.

1562 SECTION 9. Section 43-13-121, Mississippi Code of 1972, is
1563 amended as follows:

1564 43-13-121. (1) The division is authorized and empowered to
1565 administer a program of medical assistance under the provisions of
1566 this article, and to do the following:

1567 (a) Adopt and promulgate reasonable rules, regulations
1568 and standards, with approval of the Governor, and in accordance
1569 with the Administrative Procedures Law, Section 25-43-1 et seq.:

1570 (i) Establishing methods and procedures as may be

1571 necessary for the proper and efficient administration of this
1572 article;
1573 (ii) Providing medical assistance to all qualified
1574 recipients under the provisions of this article as the division
1575 may determine and within the limits of appropriated funds;
1576 (iii) Establishing reasonable fees, charges and
1577 rates for medical services and drugs; and in doing so shall fix
1578 all such fees, charges and rates at the minimum levels absolutely
1579 necessary to provide the medical assistance authorized by this
1580 article, and shall not change any such fees, charges or rates
1581 except as may be authorized in Section 43-13-117;
1582 (iv) Providing for fair and impartial hearings;
1583 (v) Providing safeguards for preserving the
1584 confidentiality of records; and
1585 (vi) For detecting and processing fraudulent
1586 practices and abuses of the program;
1587 (b) Receive and expend state, federal and other funds
1588 in accordance with court judgments or settlements and agreements
1589 between the State of Mississippi and the federal government, the
1590 rules and regulations promulgated by the division, with the
1591 approval of the Governor, and within the limitations and
1592 restrictions of this article and within the limits of funds
1593 available for such purpose;
1594 (c) Subject to the limits imposed by this article, to
1595 submit a plan for medical assistance to the federal Department of
1596 Health and Human Services for approval pursuant to the provisions
1597 of the Social Security Act, to act for the state in making
1598 negotiations relative to the submission and approval of such plan,
1599 to make such arrangements, not inconsistent with the law, as may
1600 be required by or pursuant to federal law to obtain and retain
1601 such approval and to secure for the state the benefits of the
1602 provisions of such law;
1603 No agreements, specifically including the general plan
1604 for the operation of the Medicaid program in this state, shall be

1605 made by and between the division and the Department of Health and
1606 Human Services unless the Attorney General of the State of
1607 Mississippi has reviewed the agreements, specifically including
1608 the operational plan, and has certified in writing to the Governor
1609 and to the director of the division that the agreements, including
1610 the plan of operation, have been drawn strictly in accordance with
1611 the terms and requirements of this article;
1612 (d) Pursuant to the purposes and intent of this article
1613 and in compliance with its provisions, provide for aged persons
1614 otherwise eligible for the benefits provided under Title XVIII of
1615 the federal Social Security Act by expenditure of funds available
1616 for such purposes;
1617 (e) To make reports to the federal Department of Health
1618 and Human Services as from time to time may be required by such
1619 federal department and to the Mississippi Legislature as
1620 hereinafter provided;
1621 (f) Define and determine the scope, duration and amount
1622 of medical assistance which may be provided in accordance with
1623 this article and establish priorities therefor in conformity with
1624 this article;
1625 (g) Cooperate and contract with other state agencies
1626 for the purpose of coordinating medical assistance rendered under
1627 this article and eliminating duplication and inefficiency in the
1628 program;
1629 (h) Adopt and use an official seal of the division;
1630 (i) Sue in its own name on behalf of the State of
1631 Mississippi and employ legal counsel on a contingency basis with
1632 the approval of the Attorney General;
1633 (j) To recover any and all payments incorrectly made by
1634 the division or by the Medicaid Commission to a recipient or
1635 provider from the recipient or provider receiving the payments;
1636 (k) To recover any and all payments by the division or
1637 by the Medicaid Commission fraudulently obtained by a recipient or
1638 provider. Additionally, if recovery of any payments fraudulently

1639 obtained by a recipient or provider is made in any court, then,
1640 upon motion of the Governor, the judge of the court may award
1641 twice the payments recovered as damages;
1642 (l) Have full, complete and plenary power and authority
1643 to conduct such investigations as it may deem necessary and
1644 requisite of alleged or suspected violations or abuses of the
1645 provisions of this article or of the regulations adopted hereunder
1646 including, but not limited to, fraudulent or unlawful act or deed
1647 by applicants for medical assistance or other benefits, or
1648 payments made to any person, firm or corporation under the terms,
1649 conditions and authority of this article, to suspend or disqualify
1650 any provider of services, applicant or recipient for gross abuse,
1651 fraudulent or unlawful acts for such periods, including
1652 permanently, and under such conditions as the division may deem
1653 proper and just, including the imposition of a legal rate of
1654 interest on the amount improperly or incorrectly paid. Should an
1655 administrative hearing become necessary, the division shall be
1656 authorized, should the provider not succeed in his defense, in
1657 taxing the costs of the administrative hearing, including the
1658 costs of the court reporter or stenographer and transcript, to the
1659 provider. The convictions of a recipient or a provider in a state
1660 or federal court for abuse, fraudulent or unlawful acts under this
1661 chapter shall constitute an automatic disqualification of the
1662 recipient or automatic disqualification of the provider from
1663 participation under the Medicaid program;
1664 A conviction, for the purposes of this chapter, shall
1665 include a judgment entered on a plea of nolo contendere or a
1666 nonadjudicated guilty plea and shall have the same force as a
1667 judgment entered pursuant to a guilty plea or a conviction
1668 following trial. A certified copy of the judgment of the court of
1669 competent jurisdiction of such conviction shall constitute prima
1670 facie evidence of such conviction for disqualification purposes.
1671 (m) Establish and provide such methods of
1672 administration as may be necessary for the proper and efficient

1673 operation of the program, fully utilizing computer equipment as
1674 may be necessary to oversee and control all current expenditures
1675 for purposes of this article, and to closely monitor and supervise
1676 all recipient payments and vendors rendering such services
1677 hereunder; and

1678 (n) To cooperate and contract with the federal
1679 government for the purpose of providing medical assistance to
1680 Vietnamese and Cambodian refugees, pursuant to the provisions of
1681 Public Law 94-23 and Public Law 94-24, including any amendments
1682 thereto, only to the extent that such assistance and the
1683 administrative cost related thereto are one hundred percent (100%)
1684 reimbursable by the federal government. For the purposes of
1685 Section 43-13-117, persons receiving medical assistance pursuant
1686 to Public Law 94-23 and Public Law 94-24, including any amendments
1687 thereto, shall not be considered a new group or category of
1688 recipient.

1689 (2) The division also shall exercise such additional powers
1690 and perform such other duties as may be conferred upon the
1691 division by act of the Legislature hereafter.

1692 (3) The division, and the State Department of Health as the
1693 agency for licensure of health care facilities and certification
1694 and inspection for the Medicaid and/or Medicare programs, shall
1695 contract for or otherwise provide for the consolidation of on-site
1696 inspections of health care facilities which are necessitated by
1697 the respective programs and functions of the division and the
1698 department.

1699 (4) The division and its hearing officers shall have power
1700 to preserve and enforce order during hearings; to issue subpoenas
1701 for, to administer oaths to and to compel the attendance and
1702 testimony of witnesses, or the production of books, papers,
1703 documents and other evidence, or the taking of depositions before
1704 any designated individual competent to administer oaths; to
1705 examine witnesses; and to do all things conformable to law which
1706 may be necessary to enable them effectively to discharge the

1707 duties of their office. In compelling the attendance and
1708 testimony of witnesses, or the production of books, papers,
1709 documents and other evidence, or the taking of depositions, as
1710 authorized by this section, the division or its hearing officers
1711 may designate an individual employed by the division or some other
1712 suitable person to execute and return such process, whose action
1713 in executing and returning such process shall be as lawful as if
1714 done by the sheriff or some other proper officer authorized to
1715 execute and return process in the county where the witness may
1716 reside. In carrying out the investigatory powers under the
1717 provisions of this article, the director or other designated
1718 person or persons shall be authorized to examine, obtain, copy or
1719 reproduce the books, papers, documents, medical charts,
1720 prescriptions and other records relating to medical care and
1721 services furnished by the provider to a recipient or designated
1722 recipients of Medicaid services under investigation. In the
1723 absence of the voluntary submission of the books, papers,
1724 documents, medical charts, prescriptions and other records, the
1725 Governor, the director, or other designated person shall be
1726 authorized to issue and serve subpoenas instantly upon such
1727 provider, his agent, servant or employee for the production of the
1728 books, papers, documents, medical charts, prescriptions or other
1729 records during an audit or investigation of the provider. If any
1730 provider or his agent, servant or employee should refuse to
1731 produce the records after being duly subpoenaed, the director
1732 shall be authorized to certify such facts and institute contempt
1733 proceedings in the manner, time, and place as authorized by law
1734 for administrative proceedings. As an additional remedy, the
1735 division shall be authorized to recover all amounts paid to the
1736 provider covering the period of the audit or investigation,
1737 inclusive of a legal rate of interest and a reasonable attorney's
1738 fee and costs of court if suit becomes necessary. Division staff
1739 shall have immediate access to the provider's physical location,
1740 facilities, records, documents, books, and any other records

1741 relating to medical care and services rendered to recipients
1742 during regular business hours.

1743 (5) If any person in proceedings before the division
1744 disobeys or resists any lawful order or process, or misbehaves
1745 during a hearing or so near the place thereof as to obstruct the
1746 same, or neglects to produce, after having been ordered to do so,
1747 any pertinent book, paper or document, or refuses to appear after
1748 having been subpoenaed, or upon appearing refuses to take the oath
1749 as a witness, or after having taken the oath refuses to be
1750 examined according to law, the director shall certify the facts to
1751 any court having jurisdiction in the place in which it is sitting,
1752 and the court shall thereupon, in a summary manner, hear the
1753 evidence as to the acts complained of, and if the evidence so
1754 warrants, punish such person in the same manner and to the same
1755 extent as for a contempt committed before the court, or commit
1756 such person upon the same condition as if the doing of the
1757 forbidden act had occurred with reference to the process of, or in
1758 the presence of, the court.

1759 (6) In suspending or terminating any provider from
1760 participation in the Medicaid program, the division shall preclude
1761 such provider from submitting claims for payment, either
1762 personally or through any clinic, group, corporation or other
1763 association to the division or its fiscal agents for any services
1764 or supplies provided under the Medicaid program except for those
1765 services or supplies provided prior to the suspension or
1766 termination. No clinic, group, corporation or other association
1767 which is a provider of services shall submit claims for payment to
1768 the division or its fiscal agents for any services or supplies
1769 provided by a person within such organization who has been
1770 suspended or terminated from participation in the Medicaid program
1771 except for those services or supplies provided prior to the
1772 suspension or termination. When this provision is violated by a
1773 provider of services which is a clinic, group, corporation or
1774 other association, the division may suspend or terminate such

1775 organization from participation. Suspension may be applied by the
1776 division to all known affiliates of a provider, provided that each
1777 decision to include an affiliate is made on a case-by-case basis
1778 after giving due regard to all relevant facts and circumstances.
1779 The violation, failure, or inadequacy of performance may be
1780 imputed to a person with whom the provider is affiliated where
1781 such conduct was accomplished with the course of his official duty
1782 or was effectuated by him with the knowledge or approval of such
1783 person.

1784 (7) If the division ascertains that a provider has been
1785 convicted of a felony under federal or state law for an offense
1786 which the division determines is detrimental to the best interests
1787 of the program or of Medicaid recipients, the division may refuse
1788 to enter into an agreement with such provider, or may terminate or
1789 refuse to renew an existing agreement.

1790 SECTION 10. Section 43-13-122, Mississippi Code of 1972, is
1791 amended as follows:

1792 43-13-122. (1) The division is authorized to apply to the
1793 Health Care Financing Administration of the United States
1794 Department of Health and Human Services for waivers and research
1795 and demonstration grants as are otherwise authorized by the
1796 Legislature in this chapter.

1797 * * *

1798 (2) The division is further authorized to accept and expend
1799 any grants, donations or contributions from any public or private
1800 organization together with any additional federal matching funds
1801 that may accrue and including, but not limited to, one hundred
1802 percent (100%) federal grant funds or funds from any governmental
1803 entity or instrumentality thereof in furthering the purposes and
1804 objectives of the Mississippi Medicaid program, provided that such
1805 receipts and expenditures are reported and otherwise handled in
1806 accordance with the General Fund Stabilization Act. The
1807 Department of Finance and Administration is authorized to transfer
1808 monies to the division from special funds in the State Treasury in

1809 amounts not exceeding the amounts authorized in the appropriation
1810 to the division.
1811 SECTION 11. Section 43-13-125, Mississippi Code of 1972, is
1812 amended as follows:
1813 43-13-125. (1) If medical assistance is provided to a
1814 recipient under this article for injuries, disease or sickness
1815 caused under circumstances creating a cause of action in favor of
1816 the recipient against any person, firm or corporation, then the
1817 division shall be entitled to recover the proceeds that may result
1818 from the exercise of any rights of recovery which the recipient
1819 may have against any such person, firm or corporation to the
1820 extent of the *** * *** Division of Medicaid's interest on behalf of
1821 the recipient. The recipient shall execute and deliver
1822 instruments and papers to do whatever is necessary to secure such
1823 rights and shall do nothing after the medical assistance is
1824 provided to prejudice the subrogation rights of the division.
1825 Court orders or agreements for reimbursement of Medicaid's
1826 interest shall direct such payments to the Division of Medicaid,
1827 which shall be authorized to endorse any and all *** * ***, including,
1828 but not limited to, multi-payee checks, drafts, money orders, or
1829 other negotiable instruments representing Medicaid payment
1830 recoveries that are received. In accordance with Section
1831 43-13-305, endorsement of multi-payee checks, drafts, money orders
1832 or other negotiable instruments by the Division of Medicaid shall
1833 be deemed endorsed by the recipient.
1834 The division, with the approval of the Governor, may
1835 compromise or settle any such claim and execute a release of any
1836 claim it has by virtue of this section.
1837 (2) The acceptance of medical assistance under this article
1838 or the making of a claim thereunder shall not affect the right of
1839 a recipient or his legal representative to recover Medicaid's
1840 interest as an element of special damages in any action at
1841 law; *** * *** however, *** * *** a copy of the pleadings shall be
1842 certified to the division at the time of the institution of suit,

1843 and proof of such notice shall be filed of record in such action.
1844 The division may, at any time before the trial on the facts, join
1845 in such action or may intervene therein. Any amount recovered by
1846 a recipient or his legal representative shall be applied as
1847 follows:
1848 (a) The reasonable costs of the collection, including
1849 attorney's fees, as approved and allowed by the court in which
1850 such action is pending, or in case of settlement without suit, by
1851 the legal representative of the division;
1852 (b) The *** * *** amount of <u>Medicaid's interest</u> on behalf
1853 of the recipient; or such pro rata amount as may be arrived at by
1854 the legal representative of the division and the recipient's
1855 attorney, or as set by the court having jurisdiction; and
1856 (c) Any excess shall be awarded to the recipient.
1857 (3) No compromise of any claim by the recipient or his legal
1858 representative shall be binding upon or affect the rights of the
1859 division against the third party unless the division, with the
1860 approval of the Governor, has entered into the compromise. Any
1861 compromise effected by the recipient or his legal representative
1862 with the third party in the absence of advance notification to and
1863 approved by the division shall constitute conclusive evidence of
1864 the liability of the third party, and the division, in litigating
1865 its claim against <u>the</u> third party, shall be required only to prove
1866 the amount and correctness of its claim relating to such injury,
1867 disease or sickness. It is further provided that should the
1868 recipient or his legal representative fail to notify the division
1869 of the institution of legal proceedings against a third party for
1870 which the division has a cause of action, the facts relating to
1871 negligence and the liability of the third party, if judgment is
1872 rendered for the recipient, shall constitute conclusive evidence
1873 of liability in a subsequent action maintained by the division and
1874 only the amount and correctness of the division's claim relating
1875 to injuries, disease or sickness shall be tried before the court.
1876 The division shall be authorized in bringing such action against

1877 the third party and his insurer jointly or against the insurer
1878 alone.
1879 (4) Nothing herein shall be construed to diminish or
1880 otherwise restrict the subrogation rights of the Division of
1881 Medicaid against a third party for medical assistance provided by
1882 the Division of Medicaid * * * to the recipient as a result of
1883 injuries, disease or sickness caused under circumstances creating
1884 a cause of action in favor of the recipient against such a third
1885 party.
1886 (5) Any amounts recovered by the division under this section
1887 shall, by the division, be placed to the credit of the funds
1888 appropriated for benefits under this article proportionate to the
1889 amounts provided by the state and federal governments
1890 respectively.
1891 SECTION 12. Section 43-13-137, Mississippi Code of 1972, is
1892 amended as follows:
1893 43-13-137. The division is an agency as defined under
1894 Section 25-43-3 and, therefore, must comply in all respects with
1895 the Administrative Procedures Law, Section 25-43-1 et seq.
1896 SECTION 13. Section 43-13-305, Mississippi Code of 1972, is
1897 amended as follows:
1898 43-13-305. (1) By accepting Medicaid from the Division of
1899 Medicaid in the Office of the Governor, the recipient shall, to
1900 the extent of the payment of medical expenses by the Division of
1901 Medicaid, be deemed to have made an assignment to the Division of
1902 Medicaid of any and all rights and interests in any third-party
1903 benefits, hospitalization or indemnity contract or any cause of
1904 action, past, present or future, against any person, firm or
1905 corporation for Medicaid benefits provided to the recipient by the
1906 Division of Medicaid for injuries, disease or sickness caused or
1907 suffered under circumstances creating a cause of action in favor
1908 of the recipient against any such person, firm or corporation as
1909 set out in Section 43-13-125. The recipient shall be deemed,
1910 without the necessity of signing any document, to have appointed

1911 the Division of Medicaid as his or her true and lawful
1912 attorney-in-fact in his or her name, place and stead in collecting
1913 any and all amounts due and owing for medical expenses paid by the
1914 Division of Medicaid against such person, firm or corporation.
1915 (2) Whenever a provider of medical services or the Division
1916 of Medicaid submits claims to an insurer on behalf of a Medicaid
1917 recipient for whom an assignment of rights has been received, or
1918 whose rights have been assigned by the operation of law, the
1919 insurer must respond within sixty (60) days of receipt of a claim
1920 by forwarding payment or issuing a notice of denial directly to
1921 the submitter of the claim. The failure of the insuring entity to
1922 comply with the provisions of this section shall subject the
1923 insuring entity to recourse by the Division of Medicaid in
1924 accordance with the provision of Section 43-13-315. The Division
1925 of Medicaid shall be authorized to endorse any and all, including,
1926 but not limited to, multi-payee checks, drafts, money orders or
1927 other negotiable instruments representing Medicaid payment
1928 recoveries that are received by the Division of Medicaid.
1929 (3) Court orders or agreements for medical support shall
1930 direct such payments to the Division of Medicaid, which shall be
1931 authorized to endorse any and all checks, drafts, money orders or
1932 other negotiable instruments representing medical support payments
1933 which are received. Any designated medical support funds received
1934 by the State Department of Human Services or through its local
1935 county departments shall be paid over to the Division of Medicaid.
1936 When medical support for a Medicaid recipient is available through
1937 an absent parent or custodial parent, the insuring entity shall
1938 direct the medical support payment(s) to the provider of medical
1939 services or to the Division of Medicaid.
1940 SECTION 14. Section 43-27-107, Mississippi Code of 1972, is
1941 amended as follows:
1942 43-27-107. The Department of Human Services is authorized to
1943 set the qualifications necessary for all social workers employed
1944 by the department, which shall at a minimum require state

1945 licensure as a social worker, and shall not be required to go
1946 through the State Personnel Board or use the qualifications set by
1947 the personnel board in employing social workers for the
1948 department. All social workers employed by the department shall
1949 be state service employees from the date of their employment with
1950 the department; * * * however, * * * the department is authorized
1951 to classify not more than thirty-two (32) newly established social
1952 worker positions allowed beginning in Fiscal Year 1999, and not
1953 more than forty-six (46) newly established social worker positions
1954 allowed beginning in Fiscal Year 2000, as time-limited employee
1955 positions. All social worker positions existing before July 1,
1956 1998, will remain state service.
1957 SECTION 15. This act shall take effect and be in force from
1958 and after July 1, 1999.