MISSISSIPPI LEGISLATURE REGULAR SESSION 2000

By: Holland

To: Public Health and Welfare; Appropriations

HOUSE BILL NO. 700

AN ACT TO AMEND SECTION 43-13-107, MISSISSIPPI CODE OF 1972, TO CREATE THE MISSISSIPPI MEDICAID COMMISSION TO ADMINISTER THE MEDICAID PROGRAM; TO PROVIDE FOR THE APPOINTMENT OF THE MEMBERS OF THE COMMISSION; TO ABOLISH THE DIVISION OF MEDICAID AND TRANSFER THE POWERS, DUTIES, PROPERTY AND EMPLOYEES OF THE DIVISION TO THE MEDICAID COMMISSION; TO AMEND SECTIONS 43-13-103, 43-13-105, 43-13-109, 43-13-111, 43-13-113, 43-13-115, 43-13-116, 43-13-117, 43-13-118, 43-13-120, 43-13-121, 43-13-122, 43-13-123, 43-13-125, 43-13-127 AND 43-13-139, MISSISSIPPI CODE OF 1972, TO CONFORM TO THE PRECEDING PROVISION; AND FOR RELATED PURPOSES.

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

SECTION 1. Section 43-13-107, Mississippi Code of 1972, is amended as follows:[RF1]

43-13-107. <u>(1) (a)</u> The <u>Mississippi</u> Medicaid <u>Commission</u> is * * * created * * * and established to administer this article and perform such other duties as are prescribed by law. <u>The commission shall consist of seven (7) members appointed by the Governor, with the advice and consent of the Senate. One (1) member of the commission shall be appointed from each congressional district as constituted on July 1, 2000, and two (2) members of the commission shall be appointed from the state at large. Three (3) members of the commission shall be persons who are not providers or representative of any provider of Medicaid services or have any financial or other interest in any provider of Medicaid services. All members of the commission shall be</u>

persons who have some knowledge or experience in matters under the jurisdiction of the commission.

(b) The initial members of the commission shall be appointed for staggered terms, as follows: Two (2) members shall be appointed for terms that end on June 30, 2002; three (3) members shall be appointed for terms that end on June 30, 2004; and two (2) members shall be appointed for terms that end on June 30, 2006. All subsequent appointments to the commission shall be for terms of six (6) years from the expiration date of the previous term. No person shall be appointed to the commission for more than two (2) consecutive terms. Any vacancy on the commission shall be filled by appointment of the Governor, with the advice and consent of the Senate, and the person appointed to fill the vacancy shall serve for the remainder of the unexpired term. The members of the commission shall select one (1) member to serve as chairman of the commission. The commission shall select a chairman once every two (2) years, and any person who has previously served as chairman may be reelected as chairman.

(c) Four (4) members of the commission shall constitute a quorum for the transaction of any business. The commission shall hold regular monthly meetings, and other meetings as may be necessary for the purpose of conducting such business as may be required. Members of the commission shall receive the per diem authorized under Section 25-3-69 for each day spent actually discharging their official duties, and shall receive reimbursement for mileage and necessary travel expenses incurred as provided in Section 25-3-41.

(2) (a) The commission shall employ a full-time executive director who shall be either a physician with administrative experience in a medical care or health program or a person holding a graduate degree in medical care administration, public health,

hospital administration, or the equivalent, and who shall serve at the will and pleasure of the commission. The executive director shall be the official secretary and legal custodian of the records of the commission; shall be the agent of the commission for the purpose of receiving all service of process, summons and notices directed to the commission; and shall perform such other duties as the commission may prescribe from time to time * * *.

(b) The executive director, with the approval of the commission and subject to the rules and regulations of the State Personnel Board, shall employ such professional, administrative, stenographic, secretarial, clerical and technical assistance as may be necessary to perform the duties required by the commission in administering this article and fix the compensation therefor, all in accordance with a state merit system meeting federal requirements. * * * When the salary of the executive director is not set by law, that salary shall be set by the State Personnel Board. * * * The provisions of Section 25-9-107(xv) shall apply to the executive director and other administrative heads of the commission.

(3) The Division of Medicaid in the Office of the Governor is abolished. Employees of the Division of Medicaid holding positions on June 30, 2000, shall be employees of the Mississippi Medicaid Commission on July 1, 2000. All of the powers and duties of the Division of Medicaid are transferred to the Mississippi Medicaid Commission. Any property, contractual rights and obligations and unexpended funds of the Division of Medicaid are transferred to the Mississippi Medicaid Commission.

SECTION 2. Section 43-13-103, Mississippi Code of 1972, is

amended as follows:

43-13-103. For the purpose of affording health care and remedial and institutional services in accordance with the requirement for federal grants and other assistance under Titles XVIII and XIX of the Social Security Act as amended, a statewide system of medical assistance is * * * established and shall be in effect in all political subdivisions of the state. The medical assistance program shall be known as the Medicaid program, and it shall be financed by state appropriations and federal matching funds therefor, and shall be administered by the Mississippi Medicaid Commission as * * * provided in this article.

SECTION 3. Section 43-13-105, Mississippi Code of 1972, is amended as follows:

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

(a) "Administering agency" means the Mississippi Medicaid Commission created by Section 43-13-107.

(b) "Commission" means the Mississippi Medicaid Commission created by Section 43-13-107.

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

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

(e) "Recipient" means a person who is eligible for assistance under Title XIX of the Social Security Act as amended

and under the terms of this article.

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

(g) "Division of Medicaid" or "division" when referring to the Division of Medicaid, wherever they appear in the laws of the State of Mississippi or in any rule, regulation or document, means the Mississippi Medicaid Commission.

SECTION 4. Section 43-13-109, Mississippi Code of 1972, is amended as follows:

43-13-109. The commission may adopt reasonable rules and regulations to provide for an open, competitive or qualifying examination for all employees of the commission other than the executive director, part-time consultants and professional staff members.

SECTION 5. Section 43-13-111, Mississippi Code of 1972, is amended as follows:

43-13-111. (1) Each year at such time as the commission may

require, every state health agency, as defined in Section 43-13-105, shall submit to the commission a detailed budget of all medical assistance programs rendered by the agency, a report covering funds available for the support of each program administered by it that can be matched with federal funds under Titles V, XVIII and XIX of the Social Security Act, a detailed description of each such program, and other data as may be requested by the commission. The commission shall coordinate the administration of all public health programs administered under Titles V, XVIII and XIX of the Social Security Act and * * * adopt such procedures and regulations * * * that will assure a more efficient coordination of those services.

(2) The Legislative Budget Office shall not approve the annual fiscal budget request of any state health agency for medical assistance to be rendered under this article until it receives the budget recommendations of the commission. The commission shall file its recommendation within thirty (30) days after the due date for the filing of the budget requests, and if the recommendations are not timely filed, the foregoing restrictions shall not apply.

(3) Every state health agency as defined in Section 43-13-105 shall present to the commission a quarterly estimate of expenditures to be made for medical assistance rendered under this article for that period and the Department of Finance and Administration shall not approve the quarterly estimate except upon a finding and recommendation by the commission that the requested expenditures will be reimbursable under the medical assistance plan and program adopted by the commission under this

article. The quarterly estimates * * * shall be filed by the commission with the Department of Finance and Administration at least thirty (30) days before the quarter in which the expenditures are to be made. Quarterly estimate, for purposes of this section, shall be such period as the Legislature has designated as a fiscal reporting period to be followed by the Department of Finance and Administration in making fiscal allocations.

(4) The commission shall recommend to the Legislature the combining of state appropriated funds, special funds and federal funds for health services that can be matched under the provisions of Titles V, XVIII, and XIX of the Social Security Act. However, in no way shall the provisions of this article be interpreted as authorizing a reduction in the overall range, effectiveness, and efficiency of services now encompassed under existing health programs.

(5) The commission shall organize its programs and budgets so as to secure federal funding on an exclusive or matching basis to the maximum extent possible.

SECTION 6. Section 43-13-113, Mississippi Code of 1972, is amended as follows:

43-13-113. (1) The State Treasurer shall receive on behalf of the state, and * * * execute all instruments incidental thereto, federal and other funds to be used for financing the Medicaid program under this article, and * * * place all those funds in a special fund in the State Treasury to the credit of the commission, which * * * funds shall be expended by the commission for the purposes and under the provisions of this article, and

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

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

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

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

(b) The commission's fiscal agent must pay ninety percent (90%) of all clean claims within thirty (30) days of the

date of receipt.

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

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

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

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

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

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

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

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

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

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

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

SECTION 7. Section 43-13-115, Mississippi Code of 1972, is amended as follows:

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

(1) Who are qualified for public assistance grants under provisions of Title IV-A and E of the federal Social Security Act, as amended, including those statutorily deemed to be IV-A as determined by the State Department of Human Services and certified to the commission, but not optional groups unless otherwise specifically covered in this section. For the purposes of this paragraph (1) and paragraphs (3), (4), (8), (14), (17) and (18) of this section, any reference to Title IV-A or to Part A of Title IV of the federal Social Security Act, as amended, or the state plan under Title IV-A or Part A of Title IV, shall be considered as a

reference to Title IV-A of the federal Social Security Act, as amended, and the state plan under Title IV-A, including the income and resource standards and methodologies under Title IV-A and the state plan, as they existed on July 16, 1996.

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

(3) Qualified pregnant women as defined in Section 1905(n) of the federal Social Security Act, as amended, and as determined to be eligible by the State Department of Human Services and certified to the commission, who:

(a) Would be eligible for assistance under Part A of Title IV (or would be eligible for that assistance if coverage under the state plan under Part A of Title IV included assistance under Section 407 of Title IV-A of the federal Social Security Act, as amended) if her child had been born and was living with her in the month the assistance would be paid, and the pregnancy has been medically verified; or

(b) Is a member of a family that would be eligible for assistance under the state plan under Part A of Title IV of the federal Social Security Act, as amended, under Section 407 if the plan required the payment of assistance under that section.

(4) Qualified children who are under five (5) years of age, who were born after September 30, 1983, and who meet the income and resource requirements of the state plan under Part A of Title IV of the federal Social Security Act, as amended. The

eligibility of individuals covered in this paragraph shall be determined by the State Department of Human Services and certified to the commission.

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

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

(7) (a) Persons certified by the commission who are patients in a medical facility (nursing home, hospital, tuberculosis sanatorium or institution for treatment of mental diseases), and who, except for the fact that they are patients in that medical facility, would qualify for grants under Title IV, Supplementary Security Income (SSI) benefits under Title XVI or state supplements, and those aged, blind and disabled persons who would not be eligible for Supplemental Security Income (SSI)

benefits under Title XVI or state supplements if they were not institutionalized in a medical facility but whose income is below the maximum standard set by the commission, which standard shall not exceed that prescribed by federal regulation;

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

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

(9) Individuals who are:

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

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

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

The eligibility of individuals covered in (a), (b) and (c) of

this paragraph shall be determined by the Department of Human Services.

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

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

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

(b) Whose resources do not exceed those allowed under the Supplemental Security Income (SSI) program.

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

(12) Individuals who are qualified Medicare beneficiaries (QMB) entitled to Part A Medicare as defined under Section 301, Public Law 100-360, known as the Medicare Catastrophic Coverage Act of 1988, and who meet the following criteria:

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

(b) Whose resources do not exceed two hundred percent (200%) of the amount allowed under the Supplemental Security Income (SSI) program as more fully prescribed under Section 301, Public Law 100-360.

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

(13) Individuals who are entitled to Medicare Part B as defined in Section 4501 of the Omnibus Budget Reconciliation Act of 1990, and who meet the following criteria:

(a) Whose income does not exceed one hundred twenty percent (120%) of the nonfarm official poverty level as defined by the Office of Management and Budget and revised annually * * *.

* * *

(b) Whose resources do not exceed two hundred percent (200%) of the amount allowed under the Supplemental Security Income (SSI) program as described in Section 301 of the Medicare Catastrophic Coverage Act of 1988.

The eligibility of individuals covered under this paragraph shall be determined by the commission, and those individuals determined eligible shall receive Medicare cost sharing.

(14) Individuals in families who would be eligible for the unemployed parent program under Section 407 of Title IV-A of the

federal Social Security Act, as amended, but do not receive payments under that section. The eligibility of individuals covered in this paragraph shall be determined by the Department of Human Services.

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

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

(17) In accordance with the terms of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193), persons who become ineligible for assistance under Title IV-A of the federal Social Security Act, as amended, because of increased income from or hours of employment of the caretaker relative or because of the expiration of the applicable earned income disregards, who were eligible for Medicaid for at least three (3) of the six (6) months preceding the month in which such ineligibility begins, shall be eligible for Medicaid

assistance for up to twenty-four (24) months; however, Medicaid assistance for more than twelve (12) months may be provided only if a federal waiver is obtained to provide that assistance for more than twelve (12) months and federal and state funds are available to provide that assistance.

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

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

SECTION 8. Section 43-13-116, Mississippi Code of 1972, is amended as follows:

43-13-116. (1) * * * The commission shall fully implement and carry out the administrative functions of determining the eligibility of those persons who qualify for Medicaid under Section 43-13-115.

(2) In determining Medicaid eligibility, the commission is authorized to enter into an agreement with the Secretary of the Department of Health and Human Services for the purpose of securing the transfer of eligibility information from the Social

Security Administration on those individuals receiving Supplemental Security Income (SSI) benefits under the federal Social Security Act and any other information necessary in determining Medicaid eligibility. The commission is further empowered to enter into contractual arrangements with its fiscal agent or with the State Department of Human Services in securing electronic data processing support as may be necessary.

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

(a) A request may be made either for a local regional office hearing or a state office hearing when the local regional office has made the initial decision that the claimant seeks to appeal or when the regional office has not acted with reasonable promptness in making a decision on a claim for eligibility or services. The decision from the local hearing may be appealed to the state office for a state hearing. A decision to deny, reduce or terminate benefits that is initially made at the state office

may be appealed by requesting a state hearing.

(b) A request for a hearing, either state or local, must be made in writing by the claimant or claimant's legal representative. "Legal representative" includes the claimant's authorized representative, an attorney retained by the claimant or claimant's family to represent the claimant, a paralegal representative with a legal aid services, a parent of a minor child if the claimant is a child, a legal guardian or conservator or an individual with power of attorney for the claimant. The claimant may also be represented by anyone that he or she so designates but must give the designation to the Medicaid regional office or state office in writing, if the person is not the legal representative, legal guardian, or authorized representative.

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

determine the level of hearing desired. If contact cannot be made within three (3) days of receipt of the request, the request will be assumed to be for a local hearing and scheduled accordingly. A hearing will not be scheduled until either a letter or the appropriate form is received by the regional or state office.

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

(e) The procedure for administrative hearings shall be as follows:

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

have eligibility reconsidered, he or she may reapply.

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

(iii) Upon receipt of a written request for a hearing, the request will be acknowledged in writing within twenty (20) days and a hearing scheduled. The claimant or representative will be given at least five (5) days' advance notice of the hearing date. If a local hearing is requested, the regional office will notify the claimant or representative in writing of the time and place of the local hearing. If a state hearing is requested, the state office will notify the claimant or representative in writing of the time and place of the state hearing. Generally, local hearings will be held at the regional office and state hearings will be held at the state office unless other arrangements are necessitated by the claimant's inability to travel.

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

(v) A state or local hearing request may be

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

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

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

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

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

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

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

(vii) When a request for a local hearing is received by the regional office or if the regional office is notified by the state office that a local hearing has been

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

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

(ix) The Medicaid specialist supervisor will serve as the hearing officer for a local hearing unless the Medicaid specialist supervisor actually participated in the eligibility, benefits, or services decision under appeal, in which case the Medicaid specialist supervisor must appoint a Medicaid specialist in the regional office who did not actually participate in the

decision under appeal to serve as hearing officer. The local hearing will be an informal proceeding in which the claimant or representative may present new or additional information, may question the action taken on the client's case, and will hear an explanation from agency staff as to the regulations and requirements that were applied to claimant's case in making the decision.

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

(xi) The claimant has the right to appeal a local hearing decision by requesting a state hearing in writing within fifteen (15) days of the mailing date of the notice of local hearing decision. The state hearing request should be made to the regional office. If benefits have been continued pending the local hearing process, then benefits will continue throughout the

fifteen-day advance notice period for an adverse local hearing decision. If a state hearing is timely requested within the fifteen-day period, then benefits will continue pending the state hearing process. State hearings requested after the fifteen-day local hearing advance notice period will not be accepted unless the initial thirty-day period for filing a hearing request has not expired because the local hearing was held early, in which case a state hearing request will be accepted as timely within the number of days remaining of the unexpired initial thirty-day period in addition to the fifteen-day time period. Continuation of benefits during the state hearing process, however, will only apply if the state hearing request is received within the fifteen-day advance notice period.

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

(xiii) Upon receipt of the hearing record, <u>the commission shall assign</u> an impartial hearing officer * * * to hear the case * * *. Hearing officers will be individuals with appropriate expertise employed by the <u>commission</u> and who have not

been involved in any way with the action or decision on appeal in the case. The hearing officer will review the case record and if the review shows that an error was made in the action of the agency or in the interpretation of policy, or that a change of policy has been made, the hearing officer will discuss these matters with the appropriate agency personnel and request that an appropriate adjustment be made. Appropriate agency personnel will discuss the matter with the claimant and if the claimant is agreeable to the adjustment of the claim, then agency personnel will request in writing dismissal of the hearing and the reason therefor, to be placed in the case record. If the hearing is to go forward, it shall be scheduled by the hearing officer in the manner set forth in subparagraph (iii) of this paragraph (e).

(xiv) In conducting the hearing, the state hearing officer will inform those present of the following:

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

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

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

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

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

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

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

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

record which will be submitted to the commission for further review and decision.

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

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

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

(A) The commission may consolidate the cases

and conduct a single group hearing when the only issue involved is one of a single law or agency policy;

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

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

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

(4) The commission may employ eligibility, technical, clerical and supportive staff as may be required in carrying out and fully implementing the determination of Medicaid eligibility, including conducting quality control reviews and the investigation of the improper receipt of Medicaid. Staffing needs will be set forth in the annual appropriation act for the commission.

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

SECTION 9. Section 43-13-117, Mississippi Code of 1972, is amended as follows:

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

(1) Inpatient hospital services.

(a) The commission shall allow thirty (30) days of inpatient hospital care annually for all Medicaid recipients; however, before any recipient will be allowed more than fifteen (15) days of inpatient hospital care in any one (1) year, he must obtain prior approval therefor from the commission. The commission shall be authorized to allow unlimited days in disproportionate hospitals as defined by the commission for eligible infants under the age of six (6) years.

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

(2) Outpatient hospital services. * * * Where the same services are reimbursed as clinic services, the commission may revise the rate or methodology of outpatient reimbursement to

maintain consistency, efficiency, economy and quality of care.

(3) Laboratory and x-ray services.

(4) Nursing facility services.

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

(b) From and after July 1, 1993, the commission shall implement the integrated case-mix payment and quality monitoring system developed pursuant to Section 43-13-122, which includes the fair rental system for property costs and in which recapture of depreciation is eliminated. The division may revise the reimbursement methodology for the case-mix payment system by reducing payment for hospital leave and therapeutic home leave days to the lowest case-mix category for nursing facilities, modifying the current method of scoring residents so that only

services provided at the nursing facility are considered in calculating a facility's per diem, and the commission may limit administrative and operating costs, but in no case shall these costs be less than one hundred nine percent (109%) of the median administrative and operating costs for each class of facility, not to exceed the median used to calculate the nursing facility reimbursement for fiscal year 1996, to be applied uniformly to all long-term care facilities.

(c) From and after July 1, 1997, all state-owned nursing facilities shall be reimbursed on a full reasonable costs basis. From and after July 1, 1997, payments by the commission to nursing facilities for return on equity capital shall be made at the rate paid under Medicare (Title XVIII of the Social Security Act), but shall be no less than seven and one-half percent (7.5%) nor greater than ten percent (10%).

(d) A Review Board for nursing facilities is established to conduct reviews of the commission's decision in the areas set forth below:

(i) Review shall be heard in the following areas:

(A) Matters relating to cost reports including, but not limited to, allowable costs and cost adjustments resulting from desk reviews and audits.

(B) Matters relating to the Minimum Data Set Plus (MDS +) or successor assessment formats including but not limited to audits, classifications and submissions.

(ii) The Review Board shall be composed of six (6) members, three (3) having expertise in one (1) of the two (2) areas set forth above and three (3) having expertise in the other

area set forth above. Each panel of three (3) shall only review appeals arising in its area of expertise. The members shall be appointed as follows:

(A) In each of the areas of expertise defined under subparagraphs (i)(A) and (i)(B), the commission shall appoint one (1) person chosen from the private sector nursing home industry in the state, which may include independent accountants and consultants serving the industry;

(B) In each of the areas of expertise defined under subparagraphs (i)(A) and (i)(B), the commission shall appoint one (1) person who is employed by the state who does not participate directly in desk reviews or audits of nursing facilities in the two (2) areas of review;

(C) The two (2) members appointed by the commission in each area of expertise shall appoint a third member in the same area of expertise.

In the event of a conflict of interest on the part of any Review Board members, the commission or the other two (2) panel members, as applicable, shall appoint a substitute member for conducting a specific review.

(iii) The Review Board panels shall have the power to preserve and enforce order during hearings; to issue subpoenas; to administer oaths; to compel attendance and testimony of witnesses; or to compel the production of books, papers, documents and other evidence; or the taking of depositions before any designated individual competent to administer oaths; to examine witnesses; and to do all things conformable to law that may be necessary to enable it effectively to discharge its duties. The

Review Board panels may appoint such person or persons as they shall deem proper to execute and return process in connection therewith.

(iv) The Review Board shall promulgate, publish and disseminate to nursing facility providers rules of procedure for the efficient conduct of proceedings, subject to the approval of the commission and in accordance with federal and state administrative hearing laws and regulations.

(v) Proceedings of the Review Board shall be of record.

(vi) Appeals to the Review Board shall be in writing and shall set out the issues, a statement of alleged facts and reasons supporting the provider's position. Relevant documents may also be attached. The appeal shall be filed within thirty (30) days from the date the provider is notified of the action being appealed or, if informal review procedures are taken, as provided by administrative regulations of the commission, within thirty (30) days after a decision has been rendered through informal hearing procedures.

(vii) The provider shall be notified of the hearing date by certified mail within thirty (30) days from the date the commission receives the request for appeal. Notification of the hearing date shall in no event be less than thirty (30) days before the scheduled hearing date. The appeal may be heard on shorter notice by written agreement between the provider and the commission.

(viii) Within thirty (30) days from the date of the hearing, the Review Board panel shall render a written

recommendation to the commission setting forth the issues, findings of fact and applicable law, regulations or provisions.

(ix) The commission shall, upon review of the recommendation, the proceedings and the record, prepare a written decision which shall be mailed to the nursing facility provider no later than twenty (20) days after the submission of the recommendation by the panel. The decision of the commission is final, subject only to judicial review.

(x) Appeals from a final decision shall be made to the Chancery Court of Hinds County. The appeal shall be filed with the court within thirty (30) days from the date the decision of the commission becomes final.

(xi) The action of the commission under review shall be stayed until all administrative proceedings have been exhausted.

(xii) Appeals by nursing facility providers involving any issues other than those two (2) specified in subparagraphs (i)(A) and (i)(B) shall be taken in accordance with the administrative hearing procedures established by the commission.

(e) When a facility of a category that does not require a certificate of need for construction and that could not be eligible for Medicaid reimbursement is constructed to nursing facility specifications for licensure and certification, and the facility is subsequently converted to a nursing facility under a certificate of need that authorizes conversion only and the applicant for the certificate of need was assessed an application review fee based on capital expenditures incurred in constructing

the facility, the commission shall allow reimbursement for capital expenditures necessary for construction of the facility that were incurred within the twenty-four (24) consecutive calendar months immediately preceding the date that the certificate of need authorizing the conversion was issued, to the same extent that reimbursement would be allowed for construction of a new nursing facility under a certificate of need that authorizes that construction. The reimbursement authorized in this subparagraph (e) may be made only to facilities the construction of which was completed after June 30, 1989. Before the commission shall be authorized to make the reimbursement authorized in this subparagraph (e), the commission first must have received approval from the Health Care Financing Administration of the United States Department of Health and Human Services of the change in the state Medicaid plan providing for the reimbursement.

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

(g) The commission shall develop and implement a referral process for long-term care alternatives for Medicaid beneficiaries and applicants. No Medicaid beneficiary shall be admitted to a Medicaid-certified nursing facility unless a licensed physician certifies that nursing facility care is appropriate for that person on a standardized form to be prepared and provided to nursing facilities by the commission. The physician shall forward a copy of that certification to the commission within twenty-four (24) hours after it is signed by the physician. Any physician who fails to forward the certification to the commission within the time period specified in this paragraph shall be ineligible for Medicaid reimbursement for any physician's services performed for the applicant. The commission shall determine, through an assessment of the applicant conducted within two (2) business days after receipt of the physician's certification, whether the applicant also could live appropriately and cost-effectively at home or in some other community-based setting if home- or community-based services were available to the applicant. The time limitation prescribed in this paragraph shall be waived in cases of emergency. If the commission determines that a home- or other community-based setting is appropriate and cost-effective, the commission shall:

(i) Advise the applicant or the applicant's legal representative that a home- or other community-based setting is appropriate;

(ii) Provide a proposed care plan and inform the applicant or the applicant's legal representative regarding the degree to which the services in the care plan are available in a

home- or in other community-based setting rather than nursing facility care; and

(iii) Explain that the plan and services are available only if the applicant or the applicant's legal representative chooses a home- or community-based alternative to nursing facility care, and that the applicant is free to choose nursing facility care.

The commission may provide the services described in this paragraph (g) directly or through contract with case managers from the local Area Agencies on Aging, and shall coordinate long-term care alternatives to avoid duplication with hospital discharge planning procedures.

Placement in a nursing facility may not be denied by the commission if home- or community-based services that would be more appropriate than nursing facility care are not actually available, or if the applicant chooses not to receive the appropriate home- or community-based services.

The commission shall provide an opportunity for a fair hearing under federal regulations to any applicant who is not given the choice of home- or community-based services as an alternative to institutional care.

The commission shall make full payment for long-term care alternative services.

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

(5) Periodic screening and diagnostic services for

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

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

(6) Physician's services. All fees for physicians' services that are covered only by Medicaid shall be reimbursed at ninety percent (90%) of the rate established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act), as amended, and which shall in no event be less than seventy percent (70%) of the rate established on January 1, 1994. All fees for physicians' services that are covered by both Medicare and Medicaid shall be reimbursed at ten percent (10%) of the adjusted Medicare payment established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act), as amended, and which shall in no event be less than seven percent (7%) of the adjusted Medicare payment established on January 1, 1994.

(7) (a) Home health services for eligible persons, not to exceed in cost the prevailing cost of nursing facility services, not to exceed sixty (60) visits per year.

(b) Repealed.

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

(9) Legend and other drugs as may be determined by the commission. The commission may implement a program of prior approval for drugs to the extent permitted by law. Payment by the commission for covered multiple source drugs shall be limited to the lower of the upper limits established and published by the Health Care Financing Administration (HCFA) plus a dispensing fee of Four Dollars and Ninety-one Cents ($4.91), or the estimated acquisition cost (EAC) as determined by the commission plus a dispensing fee of Four Dollars and Ninety-one Cents ($4.91), or the providers' usual and customary charge to the general public. The commission shall allow five (5) prescriptions per month for noninstitutionalized Medicaid recipients; however, exceptions for up to ten (10) prescriptions per month shall be allowed, with the approval of the commission.

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

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

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

As used in this paragraph (9), "estimated acquisition cost" means the commission's best estimate of what price providers generally are paying for a drug in the package size that providers buy most frequently. Product selection shall be made in compliance with existing state law; however, the commission may reimburse as if the prescription had been filled under the generic name. The commission may provide otherwise in the case of specified drugs when the consensus of competent medical advice is that trademarked drugs are substantially more effective.

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

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

(12) Intermediate care facility services.

(a) The commission shall make full payment to all intermediate care facilities for the mentally retarded for each day, not exceeding eighty-four (84) days per year, that a patient is absent from the facility on home leave. Payment may be made

for the following home leave days in addition to the eighty-four-day limitation: Christmas, the day before Christmas, the day after Christmas, Thanksgiving, the day before Thanksgiving and the day after Thanksgiving. However, before payment may be made for more than eighteen (18) home leave days in a year for a patient, the patient must have written authorization from a physician stating that the patient is physically and mentally able to be away from the facility on home leave. That authorization must be filed with the commission before it will be effective, and the authorization shall be effective for three (3) months from the date it is received by the commission, unless it is revoked earlier by the physician because of a change in the condition of the patient.

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

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

(14) Clinic services. Such diagnostic, preventive, therapeutic, rehabilitative or palliative services furnished to an outpatient by or under the supervision of a physician or dentist in a facility that is not a part of a hospital but that is organized and operated to provide medical care to outpatients. Clinic services shall include any services reimbursed as outpatient hospital services that may be rendered in such a facility, including those that become so after July 1, 1991. On July 1, 1999, all fees for physicians' services reimbursed under

authority of this paragraph (14) shall be reimbursed at ninety percent (90%) of the rate established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act), as amended, and which shall in no event be less than seventy percent (70%) of the rate established on January 1, 1994. All fees for physicians' services that are covered by both Medicare and Medicaid shall be reimbursed at ten percent (10%) of the adjusted Medicare payment established on January 1, 1999, and as adjusted each January thereafter, under Medicare (Title XVIII of the Social Security Act), as amended, and which shall in no event be less than seven percent (7%) of the adjusted Medicare payment established on January 1, 1994. On July 1, 1999, all fees for dentists' services reimbursed under authority of this paragraph (14) shall be increased to one hundred sixty percent (160%) of the amount of the reimbursement rate that was in effect on June 30, 1999.

(15) Home- and community-based services, as provided under Title XIX of the federal Social Security Act, as amended, under waivers, subject to the availability of funds specifically appropriated therefor by the Legislature. Payment for those services shall be limited to individuals who would be eligible for and would otherwise require the level of care provided in a nursing facility. The home- and community-based services authorized under this paragraph shall be expanded over a five-year period beginning July 1, 1999. The commission shall certify case management agencies to provide case management services and provide for home- and community-based services for eligible individuals under this paragraph. The home- and community-based

services under this paragraph and the activities performed by certified case management agencies under this paragraph shall be funded using state funds that are provided from the appropriation to the commission and used to match federal funds.

(16) Mental health services. Approved therapeutic and case management services provided by (a) an approved regional mental health/retardation center established under Sections 41-19-31 through 41-19-39, or by another community mental health service provider meeting the requirements of the Department of Mental Health to be an approved mental health/retardation center if determined necessary by the Department of Mental Health, using state funds that are provided from the appropriation to the State Department of Mental Health and used to match federal funds under a cooperative agreement between the commission and the department, or (b) a facility that is certified by the State Department of Mental Health to provide therapeutic and case management services, to be reimbursed on a fee for service basis. Any such services provided by a facility described in paragraph (b) must have the prior approval of the commission to be reimbursable under this section. After June 30, 1997, mental health services provided by regional mental health/retardation centers established under Sections 41-19-31 through 41-19-39, or by hospitals as defined in Section 41-9-3(a) and/or their subsidiaries and divisions, or by psychiatric residential treatment facilities as defined in Section 43-11-1, or by another community mental health service provider meeting the requirements of the Department of Mental Health to be an approved mental health/retardation center if determined necessary by the Department of Mental Health, shall not be

included in or provided under any capitated managed care pilot program provided for under paragraph (24) of this section.

(17) Durable medical equipment services and medical supplies restricted to patients receiving home health services unless waived on an individual basis by the commission. The commission shall not expend more than Three Hundred Thousand Dollars ($300,000.00) of state funds annually to pay for medical supplies authorized under this paragraph.

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

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

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

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

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

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

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

ninety percent (90%) of the reimbursement rate for comparable services rendered by a physician.

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

(23) Inpatient psychiatric services. Inpatient psychiatric services to be determined by the commission for recipients under age twenty-one (21) that are provided under the direction of a physician in an inpatient program in a licensed acute care psychiatric facility or in a licensed psychiatric residential treatment facility, before the recipient reaches age twenty-one (21) or, if the recipient was receiving the services immediately before he reached age twenty-one (21), before the earlier of the date he no longer requires the services or the date he reaches age twenty-two (22), as provided by federal regulations. Recipients shall be allowed forty-five (45) days per year of psychiatric services provided in acute care psychiatric facilities, and shall be allowed unlimited days of psychiatric services provided in licensed psychiatric residential treatment facilities.

(24) Managed care services in a program to be developed by the commission by a public or private provider. Notwithstanding any other provision in this article to the contrary, the commission shall establish rates of reimbursement to providers rendering care and services authorized under this section, and may revise such rates of reimbursement without amendment to this section by the Legislature for the purpose of achieving effective

and accessible health services, and for responsible containment of costs. This shall include, but not be limited to, one (1) module of capitated managed care in a rural area, and one (1) module of capitated managed care in an urban area.

(25) Birthing center services.

(26) Hospice care. As used in this paragraph, the term "hospice care" means a coordinated program of active professional medical attention within the home and outpatient and inpatient care that treats the terminally ill patient and family as a unit, employing a medically directed interdisciplinary team. The program provides relief of severe pain or other physical symptoms and supportive care to meet the special needs arising out of physical, psychological, spiritual, social and economic stresses that are experienced during the final stages of illness and during dying and bereavement and meets the Medicare requirements for participation as a hospice as provided in 42 CFR Part 418.

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

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

(29) The commission may apply for a waiver from the Department of Health and Human Services for home- and community-based services for developmentally disabled people using state funds that are provided from the appropriation to the State Department of Mental Health and used to match federal funds under

a cooperative agreement between the commission and the department, provided that funds for these services are specifically appropriated to the Department of Mental Health.

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

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

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

(33) Podiatrist services.

(34) Personal care services provided in a pilot program to not more than forty (40) residents at a location or locations to be determined by the commission and delivered by individuals qualified to provide those services, as allowed by waivers under Title XIX of the Social Security Act, as amended. The commission shall not expend more than Three Hundred Thousand Dollars ($300,000.00) annually to provide those personal care services. The commission shall develop recommendations for the effective regulation of any facilities that would provide personal care services that may become eligible for Medicaid reimbursement under

this section, and shall present those recommendations with any proposed legislation to the 1996 Regular Session of the Legislature on or before January 1, 1996.

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

(36) Nonemergency transportation services for Medicaid-eligible persons, to be provided by the Department of Human Services. The commission may contract with additional entities to administer nonemergency transportation services as it deems necessary. All providers shall have a valid driver's license, vehicle inspection sticker and a standard liability insurance policy covering the vehicle.

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

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

($700.00) per year per recipient.

Notwithstanding any provision of this article, except as authorized in the following paragraph and in Section 43-13-139, neither (a) the limitations on quantity or frequency of use of or the fees or charges for any of the care or services available to recipients under this section, nor (b) the payments or rates of reimbursement to providers rendering care or services authorized under this section to recipients, may be increased, decreased or otherwise changed from the levels in effect on July 1, 1986, unless they are authorized by an amendment to this section by the Legislature. However, the restriction in this paragraph shall not prevent the commission from changing the payments or rates of reimbursement to providers without an amendment to this section whenever those changes are required by federal law or regulation, or whenever those changes are necessary to correct administrative errors or omissions in calculating those payments or rates of reimbursement.

Notwithstanding any provision of this article, no new groups or categories of recipients and new types of care and services may be added without enabling legislation from the Mississippi Legislature, except that the commission may authorize those changes without enabling legislation when the addition of recipients or services is ordered by a court of proper authority. * * * If current or projected expenditures of the commission can be reasonably anticipated to exceed the amounts appropriated for any fiscal year, the commission shall discontinue any or all of the payment of the types of care and services as provided in this section that are deemed to be optional services

under Title XIX of the federal Social Security Act, as amended, for any period necessary to not exceed appropriated funds, and when necessary shall institute any other cost containment measures on any program or programs authorized under the article to the extent allowed under the federal law governing that program or programs, it being the intent of the Legislature that expenditures during any fiscal year shall not exceed the amounts appropriated for that fiscal year.

SECTION 10. Section 43-13-118, Mississippi Code of 1972, is amended as follows:

43-13-118. It shall be the duty of each provider participating in the Medicaid program to keep and maintain books, documents, and other records as prescribed by the commission in substantiation of its claim for services rendered Medicaid recipients, and those books, documents, and other records shall be kept and maintained for a period of five (5) years or for whatever longer period as may be required or prescribed under federal or state statutes and shall be subject to audit by the commission. The commission shall be entitled to full recoupment of the amount that the commission or the Division of Medicaid has paid any provider of medical service who has failed to keep or maintain records as required in this section.

SECTION 11. Section 43-13-120, Mississippi Code of 1972, is amended as follows:

43-13-120. (1) Any person who is a Medicaid recipient and is receiving Medicaid assistance for services provided in a long-term care facility under the provisions of Section 43-13-117 from the commission, who dies intestate and leaves no known heirs,

shall have deemed, through his acceptance of that Medicaid assistance, the commission as his beneficiary to all those funds in an amount not to exceed Two Hundred Fifty Dollars ($250.00) that are in his possession at the time of his death. Those funds, together with any accrued interest thereon, shall be reported by the long-term care facility to the State Treasurer in the manner provided in subsection (2).

(2) The report of the funds shall be verified, shall be on a form prescribed or approved by the Treasurer, and shall include (a) the name of the deceased person and his last known address before entering the long-term care facility; (b) the name and last known address of each person who may possess an interest in the funds; and (c) any other information that the Treasurer prescribes by regulation as necessary for the administration of this section. The report shall be filed with the Treasurer before November 1 of each year in which the long-term care facility has provided services to a person or persons having funds to which this section applies.

(3) Within one hundred twenty (120) days from November 1 of each year in which a report is made under subsection (2), the Treasurer shall cause notice to be published in a newspaper having general circulation in the county of this state in which is located the last known address of the person or persons named in the report who may possess an interest in the funds, or if no such person is named in the report, in the county in which is located the last known address of the deceased person before entering the long-term care facility. If no address is given in the report or if the address is outside of this state, the notice shall be

published in a newspaper having general circulation in the county in which the facility is located. The notice shall contain (a) the name of the deceased person; (b) his last known address before entering the facility; (c) the name and last known address of each person named in the report who may possess an interest in the funds; and (d) a statement that any person possessing an interest in the funds must make a claim for the funds to the Treasurer within ninety (90) days after the publication date or the funds will become the property of the State of Mississippi. In any year in which the Treasurer publishes a notice of abandoned property under Section 89-12-27, the Treasurer may combine the notice required by this section with the notice of abandoned property. The cost to the Treasurer of publishing the notice required by this section shall be paid by the commission.

(4) Each long-term care facility that makes a report of funds of a deceased person under this section shall pay over and deliver the funds, together with any accrued interest thereon, to the Treasurer not later than ten (10) days after notice of the funds has been published by the Treasurer as provided in subsection (3). If a claim to the funds is not made by any person having an interest in the funds within ninety (90) days of the published notice, the Treasurer shall place the funds in the special fund in the State Treasury to the credit of the commission, to be expended by the commission for the purposes provided under Mississippi Medicaid Law.

(5) This section shall not be applicable to any Medicaid patient in a long-term care facility of a state institution listed in Section 41-7-73, who has a personal deposit fund as provided

for in Section 41-7-90.

SECTION 12. Section 43-13-121, Mississippi Code of 1972, is amended as follows:

43-13-121. (1) The commission may administer a program of Medicaid assistance under the provisions of this article, and * * * do the following:

(a) Adopt and promulgate reasonable rules, regulations and standards * * *:

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

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

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

(iv) Providing for fair and impartial hearings;

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

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

(b) Receive and expend state, federal and other funds in accordance with court judgments or settlements and agreements between the State of Mississippi and the federal government, the

rules and regulations promulgated by the commission, and within the limitations and restrictions of this article and within the limits of funds available for that purpose;

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

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

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

(e) To make reports to the federal Department of Health and Human Services as from time to time may be required by that

federal department and to the Mississippi Legislature as hereinafter provided;

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

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

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

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

(j) To recover any and all payments incorrectly made by the commission or by the Division of Medicaid to a recipient or provider from the recipient or provider receiving those payments;

(k) To recover any and all payments by the commission or by the Division of Medicaid fraudulently obtained by a recipient or provider. Additionally, if recovery of any payments fraudulently obtained by a recipient or provider is made in any court, then, upon motion of the commission, the judge of the court may award twice the payments recovered as damages;

(l) Have full, complete and plenary power and authority to conduct such investigations as it may deem necessary and requisite of alleged or suspected violations or abuses of the provisions of this article or of the regulations adopted under this article including, but not limited to, fraudulent or unlawful

act or deed by applicants for Medicaid or other benefits, or payments made to any person, firm or corporation under the terms, conditions and authority of this article, to suspend or disqualify any provider of services, applicant or recipient for gross abuse, fraudulent or unlawful acts for such periods, including permanently, and under such conditions as the commission may deem proper and just, including the imposition of a legal rate of interest on the amount improperly or incorrectly paid. If an administrative hearing becomes necessary, the commission may, if the provider does not succeed in his defense, tax the costs of the administrative hearing, including the costs of the court reporter or stenographer and transcript, to the provider. The convictions of a recipient or a provider in a state or federal court for abuse, fraudulent or unlawful acts under this chapter shall constitute an automatic disqualification of the recipient or automatic disqualification of the provider from participation under the Medicaid program.

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

(m) Establish and provide such methods of administration as may be necessary for the proper and efficient operation of the Medicaid program, fully utilizing computer

equipment as may be necessary to oversee and control all current expenditures for purposes of this article, and to closely monitor and supervise all recipient payments and vendors rendering * * * services under this article; and

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

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

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

(4) The commission and its hearing officers shall have power to preserve and enforce order during hearings; to issue subpoenas for, to administer oaths to and to compel the attendance and testimony of witnesses, or the production of books, papers,

documents and other evidence, or the taking of depositions before any designated individual competent to administer oaths; to examine witnesses; and to do all things conformable to law that may be necessary to enable them effectively to discharge the duties of their office. In compelling the attendance and testimony of witnesses, or the production of books, papers, documents and other evidence, or the taking of depositions, as authorized by this section, the commission or its hearing officers may designate an individual employed by the commission or some other suitable person to execute and return that process, whose action in executing and returning that process shall be as lawful as if done by the sheriff or some other proper officer authorized to execute and return process in the county where the witness may reside. In carrying out the investigatory powers under the provisions of this article, the executive director or other designated person or persons may examine, obtain, copy or reproduce the books, papers, documents, medical charts, prescriptions and other records relating to medical care and services furnished by the provider to a recipient or designated recipients of Medicaid services under investigation. In the absence of the voluntary submission of those books, papers, documents, medical charts, prescriptions and other records, the commission, the executive director, or other designated person may issue and serve subpoenas instantly upon the provider, his agent, servant or employee for the production of the books, papers, documents, medical charts, prescriptions or other records during an audit or investigation of the provider. If any provider or his agent, servant or employee * * * refuses to produce the records

after being duly subpoenaed, the commission or the executive director may certify those facts and institute contempt proceedings in the manner, time, and place as authorized by law for administrative proceedings. As an additional remedy, the commission may recover all amounts paid to the provider covering the period of the audit or investigation, inclusive of a legal rate of interest and a reasonable attorney's fee and costs of court if suit becomes necessary.

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

(6) In suspending or terminating any provider from participation in the Medicaid program, the commission shall preclude the provider from submitting claims for payment, either personally or through any clinic, group, corporation or other

association to the commission or its fiscal agents for any services or supplies provided under the Medicaid program except for those services or supplies provided before the suspension or termination. No clinic, group, corporation or other association that is a provider of services shall submit claims for payment to the commission or its fiscal agents for any services or supplies provided by a person within that organization who has been suspended or terminated from participation in the Medicaid program except for those services or supplies provided before the suspension or termination. When this provision is violated by a provider of services that is a clinic, group, corporation or other association, the commission may suspend or terminate that organization from participation. Suspension may be applied by the commission to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case by case basis after giving due regard to all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the provider is affiliated where the conduct was accomplished with the course of his official duty or was effectuated by him with the knowledge or approval of that person.

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

43-13-122. (1) The commission may apply to the Health Care Financing Administration of the U.S. Department of Health and Human Services for waivers and research and demonstration grants in the following programs:

A multistate demonstration integrating case-mix payment and

quality monitoring system in nursing facilities grant to develop and implement a resident assessment and a quality monitoring system and a nursing facility reimbursement plan based on case-mix. This subsection authorizes only the participation by the commission in the demonstration described in this subsection.

(2) The commission shall implement the integrated case-mix payment and quality monitoring system developed in subsection (1) of this section, which includes the fair rental system for property costs and in which recapture of depreciation is eliminated. The commission may revise the reimbursement methodology for the case-mix payment system by reducing payment for hospital leave and therapeutic home leave days to the lowest case mix category for nursing facilities, modifying the current method of scoring residents so that only services provided at the nursing facility are considered in calculating a facility's per diem, and the commission may limit administrative and operating costs, but in no case shall these costs be less than one hundred nine percent (109%) of the median administrative and operating costs for each class of facility, not to exceed the median used to calculate the nursing facility reimbursement for fiscal year 1996, to be applied uniformly to all long-term care facilities. This subsection (2) shall stand repealed on July 1, 1997.

(3) The commission also may accept and expend any grants, donations or contributions from any public or private organization together with any additional federal matching funds that may accrue and including, but not limited to, one hundred percent (100%) federal grant funds or funds from any governmental entity or instrumentality thereof in furthering the purposes and

objectives of the Mississippi Medicaid Program, provided that those receipts and expenditures are reported and otherwise handled in accordance with the General Fund Stabilization Act. The Department of Finance and Administration may transfer monies to the commission from special funds in the State Treasury in amounts not exceeding the amounts authorized in the appropriation to the commission.

SECTION 14. Section 43-13-123, Mississippi Code of 1972, is amended as follows:

43-13-123. The determination of the method of providing payment of claims under this article shall be made by the commission, which methods may be:

(1) By contract with insurance companies licensed to do business in the State of Mississippi or with nonprofit hospital service corporations, medical or dental service corporations, authorized to do business in Mississippi to underwrite on an insured premium approach, such medical assistance benefits as may be available, and any carrier selected under the provisions of this article is * * * expressly authorized and empowered to undertake the performance of the requirements of that contract.

(2) By contract with an insurance company licensed to do business in the State of Mississippi or with nonprofit hospital service, medical or dental service organizations, or other organizations including data processing companies, authorized to do business in Mississippi to act as fiscal agent.

The commission shall solicit, receive, review, accept and award contracts for services to be provided under either of the above-described provisions after advertising for bids by

publication of notice therefor in one or more newspapers having a general circulation in the State of Mississippi, which * * * notice shall be published for at least once a week for three (3) consecutive weeks, the first publication of which shall be at least twenty-one (21) days before the date set in the notice for the receipt of bids. Final determination on acceptance of a bid for the purposes of this provision will be subject to the review and approval of the Public Procurement Review Board.

The authorization of the foregoing methods shall not preclude other methods of providing payment of claims through direct operation of the program by the state or its agencies.

SECTION 15. Section 43-13-125, Mississippi Code of 1972, is amended as follows:

43-13-125. (1) If Medicaid is provided to a recipient under this article for injuries, disease or sickness caused under circumstances creating a cause of action in favor of the recipient against any person, firm or corporation, then the commission shall be entitled to recover the proceeds that may result from the exercise of any rights of recovery which the recipient may have against any such person, firm or corporation to the extent of the actual amount of the Medicaid payments made by the commission or the Division of Medicaid on behalf of the recipient. The recipient shall execute and deliver instruments and papers to do whatever is necessary to secure those rights and shall do nothing after the Medicaid assistance is provided to prejudice the subrogation rights of the commission. Court orders or agreements for reimbursement of Medicaid payments shall direct those payments to the commission, which shall be authorized to endorse any and

all checks, drafts, money orders, or other negotiable instruments representing Medicaid payment recoveries that are received.

The commission may compromise or settle any such claim and execute a release of any claim it has by virtue of this section.

(2) The acceptance of Medicaid under this article or the making of a claim under this article shall not affect the right of a recipient or his legal representative to recover the Medicaid payments made by the commission as an element of special damages in any action at law; * * * however, * * * a copy of the pleadings shall be certified to the commission at the time of the institution of suit, and proof of that notice shall be filed of record in that action. The commission may, at any time before the trial on the facts, join in that action or may intervene in that action. Any amount recovered by a recipient or his legal representative shall be applied as follows:

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

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

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

(3) No compromise of any claim by the recipient or his legal representative shall be binding upon or affect the rights of the commission against the third party unless the commission, has

entered into the compromise. Any compromise effected by the recipient or his legal representative with the third party in the absence of advance notification to and approved by the commission shall constitute conclusive evidence of the liability of the third party, and the commission, in litigating its claim against the third party, shall be required only to prove the amount and correctness of its claim relating to the injury, disease or sickness. If the recipient or his legal representative fails to notify the commission of the institution of legal proceedings against a third party for which the commission has a cause of action, the facts relating to negligence and the liability of the third party, if judgment is rendered for the recipient, shall constitute conclusive evidence of liability in a subsequent action maintained by the commission and only the amount and correctness of the commission's claim relating to injuries, disease or sickness shall be tried before the court. The commission may bring such action against the third party and his insurer jointly or against the insurer alone.

(4) Nothing in this section shall be construed to diminish or otherwise restrict the subrogation rights of the commission against a third party for Medicaid paid by the commission or by the Division of Medicaid on behalf of the recipient as a result of injuries, disease or sickness caused under circumstances creating a cause of action in favor of the recipient against such a third party.

(5) Any amounts recovered by the commission under this section shall, by the commission, be placed to the credit of the funds appropriated for benefits under this article proportionate

to the amounts provided by the state and federal governments respectively.

SECTION 16. Section 43-13-127, Mississippi Code of 1972, is amended as follows:

43-13-127. Within sixty (60) days after the end of each fiscal year and at each regular session of the Legislature, the commission shall make and publish a report to the Governor and to the Legislature, showing for the period of time covered the following:

(a) The total number of recipients;

(b) The total amount paid for Medicaid assistance and care under this article;

(c) The total number of applications;

(d) The number of applications approved;

(e) The number of applications denied;

(f) The amount expended for administration of the provisions of this article;

(g) The amount of money received from the federal government, if any;

(h) The amount of money recovered by reason of collections from third persons by reason of assignment or subrogation, and the disposition of the same;

(i) The actions and activities of the commission in detecting and investigating suspected or alleged fraudulent practices, violations and abuses of the Medicaid program;

(j) Any recommendations it may have as to expanding, enlarging, limiting or restricting, the eligibility of persons covered by this article or services provided by this article, to

make more effective the basic purposes of this article; to eliminate or curtail fraudulent practices and inequities in the plan or administration thereof; and to continue to participate in receiving federal funds for the furnishing of medical assistance under Title XIX of the Social Security Act or other federal law.

SECTION 17. Section 43-13-139, Mississippi Code of 1972, is amended as follows:

43-13-139. Nothing contained in this article shall be construed to prevent the commission, in its discretion and through a majority vote of its members, from discontinuing or limiting Medicaid to any individuals who are classified or deemed to be within any optional group or optional category of recipients as prescribed under Title XIX of the federal Social Security Act or the implementing federal regulations. If the Congress or the United States Department of Health and Human Services ceases to provide federal matching funds for any group or category of recipients or any type of care and services, the commission shall cease state funding for that group or category or that type of care and services, notwithstanding any provision of this article.

SECTION 18. This act shall take effect and be in force from and after July 1, 2000.