By: Moody

To: Public Health and Welfare; Appropriations

HOUSE BILL NO. 1340

1 AN ACT TO BRING FORWARD FOR THE PURPOSES OF AMENDMENT
2 SECTIONS 43-13-101, 43-13-103, 43-13-105, 43-13-107, 43-13-109,
3 43-13-111, 43-13-113, 43-13-115, 43-13-116, 43-13-117, 43-13-118,
4 43-13-120, 43-13-121, 43-13-122, 43-13-123, 43-13-125, 43-13-127,
5 43-13-129, 43-13-131, 43-13-133, 43-13-137 AND 43-13-139,
6 MISSISSIPPI CODE OF 1972, WHICH ARE THE MISSISSIPPI MEDICAID LAW;
7 AND FOR RELATED PURPOSES.

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

9 SECTION 1. Section 43-13-101, Mississippi Code of 1972, is
10 brought forward as follows:[RF1]

11 43-13-101. This article shall be entitled and cited as the
12 "Mississippi Medicaid Law."

13 SECTION 2. Section 43-13-103, Mississippi Code of 1972, is
14 brought forward as follows:[RF2]

15 43-13-103. For the purpose of affording health care and
16 remedial and institutional services in accordance with the
17 requirements for federal grants and other assistance under Titles
18 XVIII and XIX of the Social Security Act as amended, a statewide
19 system of medical assistance is hereby established and shall be in
20 effect in all political subdivisions of the state, to be financed
21 by state appropriations and federal matching funds therefor, and
22 to be administered by the Office of the Governor as hereinafter
23 provided.

24 SECTION 3. Section 43-13-105, Mississippi Code of 1972, is
25 brought forward as follows:[RF3]

26 43-13-105. When used in this article, the following
27 definitions shall apply, unless the context requires otherwise:

28 (a) "Administering agency" means the Division of

29 Medicaid in the Office of the Governor as created by this article.
30 (b) "Division" or "Division of Medicaid" means the
31 Division of Medicaid in the Office of the Governor.
32 (c) "Medical assistance" means payment of part or all
33 of the costs of medical and remedial care provided under the terms
34 of this article and in accordance with provisions of Title XIX of
35 the Social Security Act as amended.
36 (d) "Applicant" means a person who applies for
37 assistance under Titles IV, XVI or XIX of the Social Security Act
38 as amended, and under the terms of this article.
39 (e) "Recipient" means a person who is eligible for
40 assistance under Title XIX of the Social Security Act as amended
41 and under the terms of this article.
42 (f) "State health agency" shall mean any agency,
43 department, institution, board or commission of the State of
44 Mississippi, except the University Medical School, which is
45 supported in whole or in part by any public funds, including funds
46 directly appropriated from the state treasury, funds derived by
47 taxes, fees levied or collected by statutory authority, or any
48 other funds used by "state health agencies" derived from federal
49 sources, when any funds available to such agency are expended
50 either directly or indirectly in connection with, or in support
51 of, any public health, hospital, hospitalization or other public
52 programs for the preventive treatment or actual medical treatment
53 of persons who are physically or mentally ill or mentally
54 retarded.
55 (g) "Mississippi Medicaid Commission" or "Medicaid
56 Commission" wherever they appear in the laws of the State of
57 Mississippi, shall mean the Division of Medicaid in the Office of
58 the Governor.
59 SECTION 4. Section 43-13-107, Mississippi Code of 1972, is
60 brought forward as follows:[RF4]
61 43-13-107. The Division of Medicaid is hereby created in the

62 Office of the Governor and established to administer this article
63 and perform such other duties as are prescribed by law.
64 The Governor shall appoint a full-time director, with the
65 advice and consent of the Senate, who shall be either a physician
66 with administrative experience in a medical care or health program
67 or a person holding a graduate degree in medical care
68 administration, public health, hospital administration, or the
69 equivalent, and who shall serve at the will and pleasure of the
70 Governor. The director shall be the official secretary and legal
71 custodian of the records of the division; shall be the agent of
72 the division for the purpose of receiving all service of process,
73 summons and notices directed to the division; and shall perform
74 such other duties as the Governor shall, from time to time,
75 prescribe. The director, with the approval of the Governor and
76 the rules and regulations of the State Personnel Board, shall
77 employ such professional, administrative, stenographic,
78 secretarial, clerical and technical assistance as may be necessary
79 to perform the duties required in administering this article and
80 fix the compensation therefor, all in accordance with a state
81 merit system meeting federal requirements, except that when the
82 salary of the director is not set by law, such salary shall be set
83 by the State Personnel Board. No employees of the Division of
84 Medicaid shall be considered to be staff members of the immediate
85 Office of the Governor; however, the provisions of Section
86 25-9-107(xv), Mississippi Code of 1972, shall apply to the
87 director and other administrative heads of the division.
88 SECTION 5. Section 43-13-109, Mississippi Code of 1972, is
89 brought forward as follows:[RF5]
90 43-13-109. The director, with the approval of the Governor
91 and pursuant to the rules and regulations of the State Personnel
92 Board, may adopt reasonable rules and regulations to provide for
93 an open, competitive or qualifying examination for all employees
94 of the division other than the director, part-time consultants and

95 professional staff members.

96 SECTION 6. Section 43-13-111, Mississippi Code of 1972, is
97 brought forward as follows:[RF6]

98 43-13-111. Annually, at such time as the division may
99 require, every state health agency, as defined in Section
100 43-13-105, shall submit to the division a detailed budget of all
101 medical assistance programs rendered by the agency, a report
102 covering funds available for the support of each program
103 administered by it that can be matched with federal funds under
104 Titles V, XVIII and XIX of the Social Security Act, a detailed
105 description of each such program, and other data as may be
106 requested by the division. The director is authorized and
107 directed to coordinate the administration of all public health
108 programs administered under Titles V, XVIII and XIX of the Social
109 Security Act and to adopt such procedures and regulations, with
110 the approval of the Governor, that will assure a more efficient
111 coordination of such services.

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

120 Every state health agency as defined in Section 43-13-105
121 shall present to the Division of Medicaid a quarterly estimate of
122 expenditures to be made for medical assistance rendered under this
123 article for such period and the State Fiscal Management Board
124 shall not approve such quarterly estimate except upon a finding
125 and recommendation by the Division of Medicaid that the requested
126 expenditures will be reimbursable under the medical assistance
127 plan and program adopted by the division pursuant to the

128 provisions of this article.
129 Quarterly estimates referred to in the foregoing paragraph
130 shall be filed by the Division of Medicaid with the State Fiscal
131 Management Board at least thirty (30) days prior to the quarter in
132 which such expenditures are to be made. Quarterly estimate, for
133 purposes of this section, shall be such period as the Legislature
134 shall hereafter designate as a fiscal reporting period to be
135 followed by the State Fiscal Management Board in making fiscal
136 allocations.
137 The division shall recommend to the Legislature the combining
138 of state appropriated funds, special funds and federal funds for
139 health services that can be matched under the provisions of Titles
140 V, XVIII, and XIX of the Social Security Act. However, in no way
141 shall the provisions of this article be interpreted as authorizing
142 a reduction in the overall range, effectiveness, and efficiency of
143 services now encompassed under existing health programs.
144 The division shall organize its programs and budgets so as to
145 secure federal funding on an exclusive or matching basis to the
146 maximum extent possible.
147 SECTION 7. Section 43-13-113, Mississippi Code of 1972, is
148 brought forward as follows:[RF7]
149 43-13-113. (1) The State Treasurer is hereby authorized and
150 directed to receive on behalf of the state, and to execute all
151 instruments incidental thereto, federal and other funds to be used
152 for financing the medical assistance plan or program adopted
153 pursuant to this article, and to place all such funds in a special
154 account to the credit of the Governor's Office-Division of
155 Medicaid, which said funds shall be expended by the division for
156 the purposes and under the provisions of this article, and shall
157 be paid out by the State Treasurer as funds appropriated to carry
158 out the provisions of this article are paid out by him.
159 The division shall issue all checks or electronic transfers
160 for administrative expenses, and for medical assistance under the

161 provisions of this article. All such checks or electronic
162 transfers shall be drawn upon funds made available to the division
163 by the State Auditor, upon requisition of the director. It is the
164 purpose of this section to provide that the State Auditor shall
165 transfer, in lump sums, amounts to the division for disbursement
166 under the regulations which shall be made by the director with the
167 approval of the Governor; provided, however, that the division, or
168 its fiscal agent in behalf of the division, shall be authorized in
169 maintaining separate accounts with a Mississippi bank to handle
170 claim payments, refund recoveries and related Medicaid program
171 financial transactions, to aggressively manage the float in these
172 accounts while awaiting clearance of checks or electronic
173 transfers and/or other disposition so as to accrue maximum
174 interest advantage of the funds in the account, and to retain all
175 earned interest on these funds to be applied to match federal
176 funds for Medicaid program operations.
177 (2) Disbursement of funds to providers shall be made as
178 follows:
179 (a) All providers must submit all claims to the
180 Division of Medicaid's fiscal agent no later than twelve (12)
181 months from the date of service.
182 (b) The Division of Medicaid's fiscal agent must pay
183 ninety percent (90%) of all clean claims within thirty (30) days
184 of the date of receipt.
185 (c) The Division of Medicaid's fiscal agent must pay
186 ninety-nine percent (99%) of all clean claims within ninety (90)
187 days of the date of receipt.
188 (d) The Division of Medicaid's fiscal agent must pay
189 all other claims within twelve (12) months of the date of receipt.
190 (e) If a claim is neither paid nor denied for valid and
191 proper reasons by the end of the time periods as specified above,
192 the Division of Medicaid's fiscal agent must pay the provider
193 interest on the claim at the rate of one and one-half percent

194 (1-1/2%) per month on the amount of such claim until it is finally
195 settled or adjudicated.
196 (3) The date of receipt is the date the fiscal agent
197 receives the claim as indicated by its date stamp on the claim or,
198 for those claims filed electronically, the date of receipt is the
199 date of transmission.
200 (4) The date of payment is the date of the check or, for
201 those claims paid by electronic funds transfer, the date of the
202 transfer.
203 (5) The above specified time limitations do not apply in the
204 following circumstances:
205 (a) Retroactive adjustments paid to providers
206 reimbursed under a retrospective payment system;
207 (b) If a claim for payment under Medicare has been
208 filed in a timely manner, the fiscal agent may pay a Medicaid
209 claim relating to the same services within six (6) months after
210 it, or the provider, receives notice of the disposition of the
211 Medicare claim;
212 (c) Claims from providers under investigation for fraud
213 or abuse; and
214 (d) The Division of Medicaid and/or its fiscal agent
215 may make payments at any time in accordance with a court order, to
216 carry out hearing decisions or corrective actions taken to resolve
217 a dispute, or to extend the benefits of a hearing decision,
218 corrective action, or court order to others in the same situation
219 as those directly affected by it.
220 (6) If sufficient funds are appropriated therefor by the
221 Legislature, the Division of Medicaid may contract with the
222 Mississippi Dental Association, or an approved designee, to
223 develop and operate a Donated Dental Services (DDS) program
224 through which volunteer dentists will treat needy disabled, aged,
225 and medically compromised individuals who are non-Medicaid
226 eligible recipients.

227 SECTION 8. Section 43-13-115, Mississippi Code of 1972, is
228 brought forward as follows:[RF8]
229 43-13-115. Recipients of medical assistance shall be the
230 following persons only:
231 (1) Who are qualified for public assistance grants under
232 provisions of Title IV-A and E of the federal Social Security Act,
233 as amended, including those statutorily deemed to be IV-A as
234 determined by the State Department of Human Services and certified
235 to the Division of Medicaid, but not optional groups unless
236 otherwise specifically covered in this section. For the purposes
237 of this paragraph (1) and paragraphs (3), (4), (8), (14), (17) and
238 (18) of this section, any reference to Title IV-A or to Part A of
239 Title IV of the federal Social Security Act, as amended, or the
240 state plan under Title IV-A or Part A of Title IV, shall be
241 considered as a reference to Title IV-A of the federal Social
242 Security Act, as amended, and the state plan under Title IV-A,
243 including the income and resource standards and methodologies
244 under Title IV-A and the state plan, as they existed on July 16,
245 1996.
246 (2) Those qualified for Supplemental Security Income (SSI)
247 benefits under Title XVI of the federal Social Security Act, as
248 amended. The eligibility of individuals covered in this paragraph
249 shall be determined by the Social Security Administration and
250 certified to the Division of Medicaid.
251 (3) Qualified pregnant women as defined in Section 1905(n)
252 of the federal Social Security Act, as amended, and as determined
253 to be eligible by the State Department of Human Services and
254 certified to the Division of Medicaid, who:
255 (a) Would be eligible for assistance under Part A of
256 Title IV (or would be eligible for such assistance if coverage
257 under the state plan under Part A of Title IV included assistance
258 pursuant to Section 407 of Title IV-A of the federal Social
259 Security Act, as amended) if her child had been born and was

260 living with her in the month such assistance would be paid, and
261 such pregnancy has been medically verified; or
262 (b) Is a member of a family which would be eligible for
263 assistance under the state plan under Part A of Title IV of the
264 federal Social Security Act, as amended, pursuant to Section 407
265 if the plan required the payment of assistance pursuant to such
266 section.
267 (4) Qualified children who are under five (5) years of age,
268 who were born after September 30, 1983, and who meet the income
269 and resource requirements of the state plan under Part A of Title
270 IV of the federal Social Security Act, as amended. The
271 eligibility of individuals covered in this paragraph shall be
272 determined by the State Department of Human Services and certified
273 to the Division of Medicaid.
274 (5) A child born on or after October 1, 1984, to a woman
275 eligible for and receiving medical assistance under the state plan
276 on the date of the child's birth shall be deemed to have applied
277 for medical assistance and to have been found eligible for such
278 assistance under such plan on the date of such birth and will
279 remain eligible for such assistance for a period of one (1) year
280 so long as the child is a member of the woman's household and the
281 woman remains eligible for such assistance or would be eligible
282 for assistance if pregnant. The eligibility of individuals
283 covered in this paragraph shall be determined by the State
284 Department of Human Services and certified to the Division of
285 Medicaid.
286 (6) Children certified by the State Department of Human
287 Services to the Division of Medicaid of whom the state and county
288 human services agency has custody and financial responsibility,
289 and children who are in adoptions subsidized in full or part by
290 the Department of Human Services, who are approvable under Title
291 XIX of the Medicaid program.
292 (7) (a) Persons certified by the Division of Medicaid who

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

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

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

315 (9) Individuals who are:

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

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

324 (c) Pregnant women and infants who have not attained
325 the age of one (1), with family income that does not exceed one

326 hundred eighty-five percent (185%) of the federal poverty level.
327 The eligibility of individuals covered in (a), (b) and (c) of
328 this paragraph shall be determined by the Department of Human
329 Services.
330 (10) Certain disabled children age eighteen (18) or under
331 who are living at home, who would be eligible, if in a medical
332 institution, for SSI or a state supplemental payment under Title
333 XVI of the federal Social Security Act, as amended, and therefore
334 for Medicaid under the plan, and for whom the state has made a
335 determination as required under Section 1902(e) (3) (b) of the
336 federal Social Security Act, as amended. The eligibility of
337 individuals under this paragraph shall be determined by the
338 Division of Medicaid.
339 (11) Individuals who are sixty-five (65) years of age or
340 older or are disabled as determined under Section 1614(a) (3) of
341 the federal Social Security Act, as amended, and who meet the
342 following criteria:
343 (a) Whose income does not exceed one hundred percent
344 (100%) of the nonfarm official poverty line as defined by the
345 Office of Management and Budget and revised annually.
346 (b) Whose resources do not exceed those allowed under
347 the Supplemental Security Income (SSI) program.
348 The eligibility of individuals covered under this paragraph
349 shall be determined by the Division of Medicaid, and such
350 individuals determined eligible shall receive the same Medicaid
351 services as other categorical eligible individuals.
352 (12) Individuals who are qualified Medicare beneficiaries
353 (QMB) entitled to Part A Medicare as defined under Section 301,
354 Public Law 100-360, known as the Medicare Catastrophic Coverage
355 Act of 1988, and who meet the following criteria:
356 (a) Whose income does not exceed one hundred percent
357 (100%) of the nonfarm official poverty line as defined by the
358 Office of Management and Budget and revised annually.

359 (b) Whose resources do not exceed two hundred percent
360 (200%) of the amount allowed under the Supplemental Security
361 Income (SSI) program as more fully prescribed under Section 301,
362 Public Law 100-360.
363 The eligibility of individuals covered under this paragraph
364 shall be determined by the Division of Medicaid, and such
365 individuals determined eligible shall receive Medicare
366 cost-sharing expenses only as more fully defined by the Medicare
367 Catastrophic Coverage Act of 1988.
368 (13) Individuals who are entitled to Medicare Part B as
369 defined in Section 4501 of the Omnibus Budget Reconciliation Act
370 of 1990, and who meet the following criteria:
371 (a) Whose income does not exceed the percentage of the
372 nonfarm official poverty line as defined by the Office of
373 Management and Budget and revised annually which, on or after:
374 (i) January 1, 1993, is one hundred ten percent
375 (110%); and
376 (ii) January 1, 1995, is one hundred twenty
377 percent (120%).
378 (b) Whose resources do not exceed two hundred percent
379 (200%) of the amount allowed under the Supplemental Security
380 Income (SSI) program as described in Section 301 of the Medicare
381 Catastrophic Coverage Act of 1988.
382 The eligibility of individuals covered under this paragraph
383 shall be determined by the Division of Medicaid, and such
384 individuals determined eligible shall receive Medicare cost
385 sharing.
386 (14) Individuals in families who would be eligible for the
387 unemployed parent program under Section 407 of Title IV-A of the
388 federal Social Security Act, as amended, but do not receive
389 payments pursuant to that section. The eligibility of individuals
390 covered in this paragraph shall be determined by the Department of
391 Human Services.

392 (15) Disabled workers who are eligible to enroll in Part A
393 Medicare as required by Public Law 101-239, known as the Omnibus
394 Budget Reconciliation Act of 1989, and whose income does not
395 exceed two hundred percent (200%) of the federal poverty level as
396 determined in accordance with the Supplemental Security Income
397 (SSI) program. The eligibility of individuals covered under this
398 paragraph shall be determined by the Division of Medicaid and such
399 individuals shall be entitled to buy-in coverage of Medicare Part
400 A premiums only under the provisions of this paragraph (15).
401 (16) In accordance with the terms and conditions of approved
402 Title XIX waiver from the United States Department of Health and
403 Human Services, persons provided home- and community-based
404 services who are physically disabled and certified by the Division
405 of Medicaid as eligible due to applying the income and deeming
406 requirements as if they were institutionalized.
407 (17) In accordance with the terms of the federal Personal
408 Responsibility and Work Opportunity Reconciliation Act of 1996
409 (Public Law 104-193), persons who become ineligible for assistance
410 under Title IV-A of the federal Social Security Act, as amended,
411 because of increased income from or hours of employment of the
412 caretaker relative or because of the expiration of the applicable
413 earned income disregards, who were eligible for Medicaid for at
414 least three (3) of the six (6) months preceding the month in which
415 such ineligibility begins, shall be eligible for Medicaid
416 assistance for up to twenty-four (24) months; however, Medicaid
417 assistance for more than twelve (12) months may be provided only
418 if a federal waiver is obtained to provide such assistance for
419 more than twelve (12) months and federal and state funds are
420 available to provide such assistance.
421 (18) Persons who become ineligible for assistance under
422 Title IV-A of the federal Social Security Act, as amended, as a
423 result, in whole or in part, of the collection or increased
424 collection of child or spousal support under Title IV-D of the

425 federal Social Security Act, as amended, who were eligible for
426 Medicaid for at least three (3) of the six (6) months immediately
427 preceding the month in which such ineligibility begins, shall be
428 eligible for Medicaid for an additional four (4) months beginning
429 with the month in which such ineligibility begins.

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

435 SECTION 9. Section 43-13-116, Mississippi Code of 1972, is
436 brought forward as follows:[RF9]

437 43-13-116. (1) It shall be the duty of the Division of
438 Medicaid to fully implement and carry out the administrative
439 functions of determining the eligibility of those persons who
440 qualify for medical assistance under Section 43-13-115.

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

452 (3) Administrative hearings shall be available to any
453 applicant who requests it because his or her claim of eligibility
454 for services is denied or is not acted upon with reasonable
455 promptness or by any recipient who requests it because he or she
456 believes the agency has erroneously taken action to deny, reduce,
457 or terminate benefits. The agency need not grant a hearing if the

458 sole issue is a federal or state law requiring an automatic change
459 adversely affecting some or all recipients. Eligibility
460 determinations that are made by other agencies and certified to
461 the Division of Medicaid pursuant to Section 43-13-115 are not
462 subject to the administrative hearing procedures of the Division
463 of Medicaid but are subject to the administrative hearing
464 procedures of the agency that determined eligibility.
465 (a) A request may be made either for a local regional
466 office hearing or a state office hearing when the local regional
467 office has made the initial decision that the claimant seeks to
468 appeal or when the regional office has not acted with reasonable
469 promptness in making a decision on a claim for eligibility or
470 services. The decision from the local hearing may be appealed to
471 the state office for a state hearing. A decision to deny, reduce
472 or terminate benefits that is initially made at the state office
473 may be appealed by requesting a state hearing.
474 (b) A request for a hearing, either state or local,
475 must be made in writing by the claimant or claimant's legal
476 representative. "Legal representative" includes the claimant's
477 authorized representative, an attorney retained by the claimant or
478 claimant's family to represent the claimant, a paralegal
479 representative with a legal aid services, a parent of a minor
480 child if the claimant is a child, a legal guardian or conservator
481 or an individual with power of attorney for the claimant. The
482 claimant may also be represented by anyone that he or she so
483 designates but must give the designation to the Medicaid regional
484 office or state office in writing, if the person is not the legal
485 representative, legal guardian, or authorized representative.
486 (c) The claimant may make a request for a hearing in
487 person at the regional office but an oral request must be put into
488 written form. Regional office staff will determine from the
489 claimant if a local or state hearing is requested and assist the
490 claimant in completing and signing the appropriate form. Regional

491 office staff may forward a state hearing request to the
492 appropriate division in the state office or the claimant may mail
493 the form to the address listed on the form. The claimant may make
494 a written request for a hearing by letter. A simple statement
495 requesting a hearing that is signed by the claimant or legal
496 representative is sufficient; however, if possible, the claimant
497 should state the reason for the request. The letter may be mailed
498 to the regional office or it may be mailed to the state office.
499 If the letter does not specify the type of hearing desired, local
500 or state, Medicaid staff will attempt to contact the claimant to
501 determine the level of hearing desired. If contact cannot be made
502 within three (3) days of receipt of the request, the request will
503 be assumed to be for a local hearing and scheduled accordingly. A
504 hearing will not be scheduled until either a letter or the
505 appropriate form is received by the regional or state office.
506 (d) When both members of a couple wish to appeal an
507 action or inaction by the agency that affects both applications or
508 cases similarly and arose from the same issue, one or both may
509 file the request for hearing, both may present evidence at the
510 hearing, and the agency's decision will be applicable to both. If
511 both file a request for hearing, two (2) hearings will be
512 registered but they will be conducted on the same day and in the
513 same place, either consecutively or jointly, as the couple wishes.
514 If they so desire, only one of the couple need attend the
515 hearing.
516 (e) The procedure for administrative hearings shall be
517 as follows:
518 (i) The claimant has thirty (30) days from the
519 date the agency mails the appropriate notice to the claimant of
520 its decision regarding eligibility, services, or benefits to
521 request either a state or local hearing. This time period may be
522 extended if the claimant can show good cause for not filing within
523 thirty (30) days. Good cause includes, but may not be limited to,

524 illness, failure to receive the notice, being out of state, or
525 some other reasonable explanation. If good cause can be shown, a
526 late request may be accepted provided the facts in the case remain
527 the same. If a claimant's circumstances have changed or if good
528 cause for filing a request beyond thirty (30) days is not shown, a
529 hearing request will not be accepted. If the claimant wishes to
530 have eligibility reconsidered, he or she may reapply.

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

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

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

557 (v) A state or local hearing request may be
558 withdrawn at any time before the scheduled hearing, or after the
559 hearing is held but before a decision is rendered. The withdrawal
560 must be in writing and signed by the claimant or representative.
561 A hearing request will be considered abandoned if the claimant or
562 representative fails to appear at a scheduled hearing without good
563 cause. If no one appears for a hearing, the appropriate office
564 will notify the claimant in writing that the hearing is dismissed
565 unless good cause is shown for not attending. The proposed agency
566 action will be taken on the case following failure to appear for a
567 hearing if the action has not already been effected.
568 (vi) The claimant or his representative has the
569 following rights in connection with a local or state hearing:
570 (A) The right to examine at a reasonable time
571 before the date of the hearing and during the hearing the content
572 of the claimant's case record;
573 (B) The right to have legal representation at
574 the hearing and to bring witnesses;
575 (C) The right to produce documentary evidence
576 and establish all facts and circumstances concerning eligibility,
577 services, or benefits;
578 (D) The right to present an argument without
579 undue interference;
580 (E) The right to question or refute any
581 testimony or evidence including an opportunity to confront and
582 cross-examine adverse witnesses.
583 (vii) When a request for a local hearing is
584 received by the regional office or if the regional office is
585 notified by the state office that a local hearing has been
586 requested, the Medicaid specialist supervisor in the regional
587 office will review the case record, re-examine the action taken on
588 the case, and determine if policy and procedures have been
589 followed. If any adjustments or corrections should be made, the

590 Medicaid specialist supervisor will ensure that corrective action
591 is taken. If the request for hearing was timely made such that
592 continuation of benefits applies, the Medicaid specialist
593 supervisor will ensure that benefits continue at the level before
594 the proposed adverse action that is the subject of the appeal.
595 The Medicaid specialist supervisor will also ensure that all
596 needed information, verification, and evidence is in the case
597 record for the hearing.
598 (viii) When a state hearing is requested that
599 appeals the action or inaction of a regional office, the regional
600 office will prepare copies of the case record and forward it to
601 the appropriate division in the state office no later than five
602 (5) days after receipt of the request for a state hearing. The
603 original case record will remain in the regional office. Either
604 the original case record in the regional office or the copy
605 forwarded to the state office will be available for inspection by
606 the claimant or claimant's representative a reasonable time before
607 the date of the hearing.
608 (ix) The Medicaid specialist supervisor will serve
609 as the hearing officer for a local hearing unless the Medicaid
610 specialist supervisor actually participated in the eligibility,
611 benefits, or services decision under appeal, in which case the
612 Medicaid specialist supervisor must appoint a Medicaid specialist
613 in the regional office who did not actually participate in the
614 decision under appeal to serve as hearing officer. The local
615 hearing will be an informal proceeding in which the claimant or
616 representative may present new or additional information, may
617 question the action taken on the client's case, and will hear an
618 explanation from agency staff as to the regulations and
619 requirements that were applied to claimant's case in making the
620 decision.
621 (x) After the hearing, the hearing officer will
622 prepare a written summary of the hearing procedure and file it

623 with the case record. The hearing officer will consider the facts
624 presented at the local hearing in reaching a decision. The
625 claimant will be notified of the local hearing decision on the
626 appropriate form that will state clearly the reason for the
627 decision, the policy that governs the decision, the claimant's
628 right to appeal the decision to the state office, and, if the
629 original adverse action is upheld, the new effective date of the
630 reduction or termination of benefits or services if continuation
631 of benefits applied during the hearing process. The new effective
632 date of the reduction or termination of benefits or services must
633 be at the end of the fifteen-day advance notice period from the
634 mailing date of the notice of hearing decision. The notice to
635 claimant will be made part of the case record.
636 (xi) The claimant has the right to appeal a local
637 hearing decision by requesting a state hearing in writing within
638 fifteen (15) days of the mailing date of the notice of local
639 hearing decision. The state hearing request should be made to the
640 regional office. If benefits have been continued pending the
641 local hearing process, then benefits will continue throughout the
642 fifteen-day advance notice period for an adverse local hearing
643 decision. If a state hearing is timely requested within the
644 fifteen-day period, then benefits will continue pending the state
645 hearing process. State hearings requested after the fifteen-day
646 local hearing advance notice period will not be accepted unless
647 the initial thirty-day period for filing a hearing request has not
648 expired because the local hearing was held early, in which case a
649 state hearing request will be accepted as timely within the number
650 of days remaining of the unexpired initial thirty-day period in
651 addition to the fifteen-day time period. Continuation of benefits
652 during the state hearing process, however, will only apply if the
653 state hearing request is received within the fifteen-day advance
654 notice period.
655 (xii) When a request for a state hearing is

656 received in the regional office, the request will be made part of
657 the case record and the regional office will prepare the case
658 record and forward it to the appropriate division in the state
659 office within five (5) days of receipt of the state hearing
660 request. A request for a state hearing received in the state
661 office will be forwarded to the regional office for inclusion in
662 the case record and the regional office will prepare the case
663 record and forward it to the appropriate division in the state
664 office within five (5) days of receipt of the state hearing
665 request.
666 (xiii) Upon receipt of the hearing record, an
667 impartial hearing officer will be assigned to hear the case either
668 by the Executive Director of the Division of Medicaid or his or
669 her designee. Hearing officers will be individuals with
670 appropriate expertise employed by the division and who have not
671 been involved in any way with the action or decision on appeal in
672 the case. The hearing officer will review the case record and if
673 the review shows that an error was made in the action of the
674 agency or in the interpretation of policy, or that a change of
675 policy has been made, the hearing officer will discuss these
676 matters with the appropriate agency personnel and request that an
677 appropriate adjustment be made. Appropriate agency personnel will
678 discuss the matter with the claimant and if the claimant is
679 agreeable to the adjustment of the claim, then agency personnel
680 will request in writing dismissal of the hearing and the reason
681 therefor, to be placed in the case record. If the hearing is to
682 go forward, it shall be scheduled by the hearing officer in the
683 manner set forth in subparagraph (iii) of this paragraph (e).
684 (xiv) In conducting the hearing, the state hearing
685 officer will inform those present of the following:
686 (A) That the hearing will be recorded on tape
687 and that a transcript of the proceedings will be typed for the
688 record;

689 (B) The action taken by the agency which
690 prompted the appeal;
691 (C) An explanation of the claimant's rights
692 during the hearing as outlined in subparagraph (vi) of this
693 paragraph (e);
694 (D) That the purpose of the hearing is for
695 the claimant to express dissatisfaction and present additional
696 information or evidence;
697 (E) That the case record is available for
698 review by the claimant or representative during the hearing;
699 (F) That the final hearing decision will be
700 rendered by the Executive Director of the Division of Medicaid on
701 the basis of facts presented at the hearing and the case record
702 and that the claimant will be notified by letter of the final
703 decision.
704 (xv) During the hearing, the claimant and/or
705 representative will be allowed an opportunity to make a full
706 statement concerning the appeal and will be assisted, if
707 necessary, in disclosing all information on which the claim is
708 based. All persons representing the claimant and those
709 representing the Division of Medicaid will have the opportunity to
710 state all facts pertinent to the appeal. The hearing officer may
711 recess or continue the hearing for a reasonable time should
712 additional information or facts be required or if some change in
713 the claimant's circumstances occurs during the hearing process
714 which impacts the appeal. When all information has been
715 presented, the hearing officer will close the hearing and stop the
716 recorder.
717 (xvi) Immediately following the hearing the
718 hearing tape will be transcribed and a copy of the transcription
719 forwarded to the regional office for filing in the case record.
720 As soon as possible, the hearing officer shall review the evidence
721 and record of the proceedings, testimony, exhibits, and other

722 supporting documents, prepare a written summary of the facts as
723 the hearing officer finds them, and prepare a written
724 recommendation of action to be taken by the agency, citing
725 appropriate policy and regulations that govern the recommendation.
726 The decision cannot be based on any material, oral or written,
727 not available to the claimant before or during the hearing. The
728 hearing officer's recommendation will become part of the case
729 record which will be submitted to the Executive Director of the
730 Division of Medicaid for further review and decision.

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

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

755 (xix) A group hearing may be held for a number of
756 claimants under the following circumstances:
757 (A) The Division of Medicaid may consolidate
758 the cases and conduct a single group hearing when the only issue
759 involved is one of a single law or agency policy;
760 (B) The claimants may request a group hearing
761 when there is one issue of agency policy common to all of them.
762 In all group hearings, whether initiated by the Division of
763 Medicaid or by the claimants, the policies governing fair hearings
764 must be followed. Each claimant in a group hearing must be
765 permitted to present his or her own case and be represented by his
766 or her own representative, or to withdraw from the group hearing
767 and have his or her appeal heard individually. As in individual
768 hearings, the hearing will be conducted only on the issue being
769 appealed, and each claimant will be expected to keep individual
770 testimony within a reasonable time frame as a matter of
771 consideration to the other claimants involved.
772 (xx) Any specific matter necessitating an
773 administrative hearing not otherwise provided under this article
774 or agency policy shall be afforded under the hearing procedures as
775 outlined above. If the specific time frames of such a unique
776 matter relating to requesting, granting, and concluding of the
777 hearing is contrary to the time frames as set out in the hearing
778 procedures above, the specific time frames will govern over the
779 time frames as set out within these procedures.
780 (4) The Executive Director of the Division of Medicaid, with
781 the approval of the Governor, shall be authorized to employ
782 eligibility, technical, clerical and supportive staff as may be
783 required in carrying out and fully implementing the determination
784 of Medicaid eligibility, including conducting quality control
785 reviews and the investigation of the improper receipt of medical
786 assistance. Staffing needs will be set forth in the annual
787 appropriation act for the division. Additional office space as

788 needed in performing eligibility, quality control and
789 investigative functions shall be obtained by the division.
790 SECTION 10. Section 43-13-117, Mississippi Code of 1972, is
791 brought forward as follows:[RF10]
792 43-13-117. Medical assistance as authorized by this article
793 shall include payment of part or all of the costs, at the
794 discretion of the division or its successor, with approval of the
795 Governor, of the following types of care and services rendered to
796 eligible applicants who shall have been determined to be eligible
797 for such care and services, within the limits of state
798 appropriations and federal matching funds:
799 (1) Inpatient hospital services.
800 (a) The division shall allow thirty (30) days of
801 inpatient hospital care annually for all Medicaid recipients;
802 however, before any recipient will be allowed more than fifteen
803 (15) days of inpatient hospital care in any one (1) year, he must
804 obtain prior approval therefor from the division. The division
805 shall be authorized to allow unlimited days in disproportionate
806 hospitals as defined by the division for eligible infants under
807 the age of six (6) years.
808 (b) From and after July 1, 1994, the Executive Director
809 of the Division of Medicaid shall amend the Mississippi Title XIX
810 Inpatient Hospital Reimbursement Plan to remove the occupancy rate
811 penalty from the calculation of the Medicaid Capital Cost
812 Component utilized to determine total hospital costs allocated to
813 the Medicaid program.
814 (2) Outpatient hospital services. Provided that where the
815 same services are reimbursed as clinic services, the division may
816 revise the rate or methodology of outpatient reimbursement to
817 maintain consistency, efficiency, economy and quality of care.
818 (3) Laboratory and x-ray services.
819 (4) Nursing facility services.
820 (a) The division shall make full payment to nursing

821 facilities for each day, not exceeding fifty-two (52) days per
822 year, that a patient is absent from the facility on home leave.
823 Payment may be made for the following home leave days in addition
824 to the fifty-two-day limitation: Christmas, the day before
825 Christmas, the day after Christmas, Thanksgiving, the day before
826 Thanksgiving and the day after Thanksgiving. However, before
827 payment may be made for more than eighteen (18) home leave days in
828 a year for a patient, the patient must have written authorization
829 from a physician stating that the patient is physically and
830 mentally able to be away from the facility on home leave. Such
831 authorization must be filed with the division before it will be
832 effective and the authorization shall be effective for three (3)
833 months from the date it is received by the division, unless it is
834 revoked earlier by the physician because of a change in the
835 condition of the patient.
836 (b) From and after July 1, 1993, the division shall
837 implement the integrated case-mix payment and quality monitoring
838 system developed pursuant to Section 43-13-122, which includes the
839 fair rental system for property costs and in which recapture of
840 depreciation is eliminated. The division may revise the
841 reimbursement methodology for the case-mix payment system by
842 reducing payment for hospital leave and therapeutic home leave
843 days to the lowest case-mix category for nursing facilities,
844 modifying the current method of scoring residents so that only
845 services provided at the nursing facility are considered in
846 calculating a facility's per diem, and the division may limit
847 administrative and operating costs, but in no case shall these
848 costs be less than one hundred nine percent (109%) of the median
849 administrative and operating costs for each class of facility, not
850 to exceed the median used to calculate the nursing facility
851 reimbursement for fiscal year 1996, to be applied uniformly to all
852 long-term care facilities.
853 (c) From and after July 1, 1997, all state-owned

854 nursing facilities shall be reimbursed on a full reasonable costs
855 basis. From and after July 1, 1997, payments by the division to
856 nursing facilities for return on equity capital shall be made at
857 the rate paid under Medicare (Title XVIII of the Social Security
858 Act), but shall be no less than seven and one-half percent (7.5%)
859 nor greater than ten percent (10%).
860 (d) A Review Board for nursing facilities is
861 established to conduct reviews of the Division of Medicaid's
862 decision in the areas set forth below:
863 (i) Review shall be heard in the following areas:
864 (A) Matters relating to cost reports
865 including, but not limited to, allowable costs and cost
866 adjustments resulting from desk reviews and audits.
867 (B) Matters relating to the Minimum Data Set
868 Plus (MDS +) or successor assessment formats including but not
869 limited to audits, classifications and submissions.
870 (ii) The Review Board shall be composed of six (6)
871 members, three (3) having expertise in one (1) of the two (2)
872 areas set forth above and three (3) having expertise in the other
873 area set forth above. Each panel of three (3) shall only review
874 appeals arising in its area of expertise. The members shall be
875 appointed as follows:
876 (A) In each of the areas of expertise defined
877 under subparagraphs (i)(A) and (i)(B), the Executive Director of
878 the Division of Medicaid shall appoint one (1) person chosen from
879 the private sector nursing home industry in the state, which may
880 include independent accountants and consultants serving the
881 industry;
882 (B) In each of the areas of expertise defined
883 under subparagraphs (i)(A) and (i)(B), the Executive Director of
884 the Division of Medicaid shall appoint one (1) person who is
885 employed by the state who does not participate directly in desk
886 reviews or audits of nursing facilities in the two (2) areas of

887 review;

888 (C) The two (2) members appointed by the

889 Executive Director of the Division of Medicaid in each area of

890 expertise shall appoint a third member in the same area of

891 expertise.

892 In the event of a conflict of interest on the part of any

893 Review Board members, the Executive Director of the Division of

894 Medicaid or the other two (2) panel members, as applicable, shall

895 appoint a substitute member for conducting a specific review.

896 (iii) The Review Board panels shall have the power

897 to preserve and enforce order during hearings; to issue subpoenas;

898 to administer oaths; to compel attendance and testimony of

899 witnesses; or to compel the production of books, papers, documents

900 and other evidence; or the taking of depositions before any

901 designated individual competent to administer oaths; to examine

902 witnesses; and to do all things conformable to law that may be

903 necessary to enable it effectively to discharge its duties. The

904 Review Board panels may appoint such person or persons as they

905 shall deem proper to execute and return process in connection

906 therewith.

907 (iv) The Review Board shall promulgate, publish

908 and disseminate to nursing facility providers rules of procedure

909 for the efficient conduct of proceedings, subject to the approval

910 of the Executive Director of the Division of Medicaid and in

911 accordance with federal and state administrative hearing laws and

912 regulations.

913 (v) Proceedings of the Review Board shall be of

914 record.

915 (vi) Appeals to the Review Board shall be in

916 writing and shall set out the issues, a statement of alleged facts

917 and reasons supporting the provider's position. Relevant

918 documents may also be attached. The appeal shall be filed within

919 thirty (30) days from the date the provider is notified of the

920 action being appealed or, if informal review procedures are taken,
921 as provided by administrative regulations of the Division of
922 Medicaid, within thirty (30) days after a decision has been
923 rendered through informal hearing procedures.

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

931 (viii) Within thirty (30) days from the date of
932 the hearing, the Review Board panel shall render a written
933 recommendation to the Executive Director of the Division of
934 Medicaid setting forth the issues, findings of fact and applicable
935 law, regulations or provisions.

936 (ix) The Executive Director of the Division of
937 Medicaid shall, upon review of the recommendation, the proceedings
938 and the record, prepare a written decision which shall be mailed
939 to the nursing facility provider no later than twenty (20) days
940 after the submission of the recommendation by the panel. The
941 decision of the executive director is final, subject only to
942 judicial review.

943 (x) Appeals from a final decision shall be made to
944 the Chancery Court of Hinds County. The appeal shall be filed
945 with the court within thirty (30) days from the date the decision
946 of the Executive Director of the Division of Medicaid becomes
947 final.

948 (xi) The action of the Division of Medicaid under
949 review shall be stayed until all administrative proceedings have
950 been exhausted.

951 (xii) Appeals by nursing facility providers
952 involving any issues other than those two (2) specified in

953 subparagraphs (i)(A) and <u>(i)</u>(B) shall be taken in accordance with
954 the administrative hearing procedures established by the Division
955 of Medicaid.

956 (e) When a facility of a category that does not require
957 a certificate of need for construction and that could not be
958 eligible for Medicaid reimbursement is constructed to nursing
959 facility specifications for licensure and certification, and the
960 facility is subsequently converted to a nursing facility pursuant
961 to a certificate of need that authorizes conversion only and the
962 applicant for the certificate of need was assessed an application
963 review fee based on capital expenditures incurred in constructing
964 the facility, the division shall allow reimbursement for capital
965 expenditures necessary for construction of the facility that were
966 incurred within the twenty-four (24) consecutive calendar months
967 immediately preceding the date that the certificate of need
968 authorizing such conversion was issued, to the same extent that
969 reimbursement would be allowed for construction of a new nursing
970 facility pursuant to a certificate of need that authorizes such
971 construction. The reimbursement authorized in this subparagraph
972 (e) may be made only to facilities the construction of which was
973 completed after June 30, 1989. Before the division shall be
974 authorized to make the reimbursement authorized in this
975 subparagraph (e), the division first must have received approval
976 from the Health Care Financing Administration of the United States
977 Department of Health and Human Services of the change in the state
978 Medicaid plan providing for such reimbursement.

979 (f) The division shall develop and implement a case-mix
980 payment add-on determined by time studies and other valid
981 statistical data which will reimburse a nursing facility for the
982 additional cost of caring for a resident who has a diagnosis of
983 Alzheimer's or other related dementia and exhibits symptoms that
984 require special care. Any such case-mix add-on payment shall be
985 supported by a determination of additional cost. The division

986 shall also develop and implement as part of the fair rental
987 reimbursement system for nursing facility beds, an Alzheimer's
988 resident bed depreciation enhanced reimbursement system which will
989 provide an incentive to encourage nursing facilities to convert or
990 construct beds for residents with Alzheimer's or other related
991 dementia.

992 (g) The Division of Medicaid shall develop and
993 implement a referral process for long-term care alternatives for
994 Medicaid beneficiaries and applicants. No Medicaid beneficiary
995 shall be admitted to a Medicaid-certified nursing facility unless
996 a licensed physician certifies that nursing facility care is
997 appropriate for that person on a standardized form to be prepared
998 and provided to nursing facilities by the Division of Medicaid.
999 The physician shall forward a copy of that certification to the
1000 Division of Medicaid within twenty-four (24) hours after it is
1001 signed by the physician. Any physician who fails to forward the
1002 certification to the Division of Medicaid within the time period
1003 specified in this paragraph shall be ineligible for Medicaid
1004 reimbursement for any physician's services performed for the
1005 applicant. The Division of Medicaid shall determine, through an
1006 assessment of the applicant conducted within two (2) business days
1007 after receipt of the physician's certification, whether the
1008 applicant also could live appropriately and cost-effectively at
1009 home or in some other community-based setting if home- or
1010 community-based services were available to the applicant. The
1011 time limitation prescribed in this paragraph shall be waived in
1012 cases of emergency. If the Division of Medicaid determines that a
1013 home- or other community-based setting is appropriate and
1014 cost-effective, the division shall:

1015 (i) Advise the applicant or the applicant's legal
1016 representative that a home- or other community-based setting is
1017 appropriate;

1018 (ii) Provide a proposed care plan and inform the

1019 applicant or the applicant's legal representative regarding the
1020 degree to which the services in the care plan are available in a
1021 home- or in other community-based setting rather than nursing
1022 facility care; and
1023 (iii) Explain that such plan and services are
1024 available only if the applicant or the applicant's legal
1025 representative chooses a home- or community-based alternative to
1026 nursing facility care, and that the applicant is free to choose
1027 nursing facility care.
1028 The Division of Medicaid may provide the services described
1029 in this paragraph (g) directly or through contract with case
1030 managers from the local Area Agencies on Aging, and shall
1031 coordinate long-term care alternatives to avoid duplication with
1032 hospital discharge planning procedures.
1033 Placement in a nursing facility may not be denied by the
1034 division if home- or community-based services that would be more
1035 appropriate than nursing facility care are not actually available,
1036 or if the applicant chooses not to receive the appropriate home-
1037 or community-based services.
1038 The division shall provide an opportunity for a fair hearing
1039 under federal regulations to any applicant who is not given the
1040 choice of home- or community-based services as an alternative to
1041 institutional care.
1042 The division shall make full payment for long-term care
1043 alternative services.
1044 The division shall apply for necessary federal waivers to
1045 assure that additional services providing alternatives to nursing
1046 facility care are made available to applicants for nursing
1047 facility care.
1048 (5) Periodic screening and diagnostic services for
1049 individuals under age twenty-one (21) years as are needed to
1050 identify physical and mental defects and to provide health care
1051 treatment and other measures designed to correct or ameliorate

1052 defects and physical and mental illness and conditions discovered
1053 by the screening services regardless of whether these services are
1054 included in the state plan. The division may include in its
1055 periodic screening and diagnostic program those discretionary
1056 services authorized under the federal regulations adopted to
1057 implement Title XIX of the federal Social Security Act, as
1058 amended. The division, in obtaining physical therapy services,
1059 occupational therapy services, and services for individuals with
1060 speech, hearing and language disorders, may enter into a
1061 cooperative agreement with the State Department of Education for
1062 the provision of such services to handicapped students by public
1063 school districts using state funds which are provided from the
1064 appropriation to the Department of Education to obtain federal
1065 matching funds through the division. The division, in obtaining
1066 medical and psychological evaluations for children in the custody
1067 of the State Department of Human Services may enter into a
1068 cooperative agreement with the State Department of Human Services
1069 for the provision of such services using state funds which are
1070 provided from the appropriation to the Department of Human
1071 Services to obtain federal matching funds through the division.
1072 On July 1, 1993, all fees for periodic screening and
1073 diagnostic services under this paragraph (5) shall be increased by
1074 twenty-five percent (25%) of the reimbursement rate in effect on
1075 June 30, 1993.
1076 (6) Physician's services. All fees for physicians' services
1077 that are covered only by Medicaid shall be reimbursed at ninety
1078 percent (90%) of the rate established on January 1, 1999, and as
1079 adjusted each January thereafter, under Medicare (Title XVIII of
1080 the Social Security Act), as amended, and which shall in no event
1081 be less than seventy percent (70%) of the rate established on
1082 January 1, 1994. All fees for physicians' services that are
1083 covered by both Medicare and Medicaid shall be reimbursed at ten
1084 percent (10%) of the adjusted Medicare payment established on

1085 January 1, 1999, and as adjusted each January thereafter, under
1086 Medicare (Title XVIII of the Social Security Act), as amended, and
1087 which shall in no event be less than seven percent (7%) of the
1088 adjusted Medicare payment established on January 1, 1994.
1089 (7) (a) Home health services for eligible persons, not to
1090 exceed in cost the prevailing cost of nursing facility services,
1091 not to exceed sixty (60) visits per year.
1092 (b) Repealed.
1093 (8) Emergency medical transportation services. On January
1094 1, 1994, emergency medical transportation services shall be
1095 reimbursed at seventy percent (70%) of the rate established under
1096 Medicare (Title XVIII of the Social Security Act), as amended.
1097 "Emergency medical transportation services" shall mean, but shall
1098 not be limited to, the following services by a properly permitted
1099 ambulance operated by a properly licensed provider in accordance
1100 with the Emergency Medical Services Act of 1974 (Section 41-59-1
1101 et seq.): (i) basic life support, (ii) advanced life support,
1102 (iii) mileage, (iv) oxygen, (v) intravenous fluids, (vi)
1103 disposable supplies, (vii) similar services.
1104 (9) Legend and other drugs as may be determined by the
1105 division. The division may implement a program of prior approval
1106 for drugs to the extent permitted by law. Payment by the division
1107 for covered multiple source drugs shall be limited to the lower of
1108 the upper limits established and published by the Health Care
1109 Financing Administration (HCFA) plus a dispensing fee of Four
1110 Dollars and Ninety-one Cents ($4.91), or the estimated acquisition
1111 cost (EAC) as determined by the division plus a dispensing fee of
1112 Four Dollars and Ninety-one Cents ($4.91), or the providers' usual
1113 and customary charge to the general public. The division shall
1114 allow five (5) prescriptions per month for noninstitutionalized
1115 Medicaid recipients; however, exceptions for up to ten (10)
1116 prescriptions per month shall be allowed, with the approval of the
1117 director.

1118 Payment for other covered drugs, other than multiple source
1119 drugs with HCFA upper limits, shall not exceed the lower of the
1120 estimated acquisition cost as determined by the division plus a
1121 dispensing fee of Four Dollars and Ninety-one Cents ($4.91) or the
1122 providers' usual and customary charge to the general public.
1123 Payment for nonlegend or over-the-counter drugs covered on
1124 the division's formulary shall be reimbursed at the lower of the
1125 division's estimated shelf price or the providers' usual and
1126 customary charge to the general public. No dispensing fee shall
1127 be paid.
1128 The division shall develop and implement a program of payment
1129 for additional pharmacist services, with payment to be based on
1130 demonstrated savings, but in no case shall the total payment
1131 exceed twice the amount of the dispensing fee.
1132 As used in this paragraph (9), "estimated acquisition cost"
1133 means the division's best estimate of what price providers
1134 generally are paying for a drug in the package size that providers
1135 buy most frequently. Product selection shall be made in
1136 compliance with existing state law; however, the division may
1137 reimburse as if the prescription had been filled under the generic
1138 name. The division may provide otherwise in the case of specified
1139 drugs when the consensus of competent medical advice is that
1140 trademarked drugs are substantially more effective.
1141 (10) Dental care that is an adjunct to treatment of an acute
1142 medical or surgical condition; services of oral surgeons and
1143 dentists in connection with surgery related to the jaw or any
1144 structure contiguous to the jaw or the reduction of any fracture
1145 of the jaw or any facial bone; and emergency dental extractions
1146 and treatment related thereto. On July 1, 1999, all fees for
1147 dental care and surgery under authority of this paragraph (10)
1148 shall be increased to one hundred sixty percent (160%) of the
1149 amount of the reimbursement rate that was in effect on June 30,
1150 1999. It is the intent of the Legislature to encourage more

1151 dentists to participate in the Medicaid program.
1152 (11) Eyeglasses necessitated by reason of eye surgery, and
1153 as prescribed by a physician skilled in diseases of the eye or an
1154 optometrist, whichever the patient may select.
1155 (12) Intermediate care facility services.
1156 (a) The division shall make full payment to all
1157 intermediate care facilities for the mentally retarded for each
1158 day, not exceeding eighty-four (84) days per year, that a patient
1159 is absent from the facility on home leave. Payment may be made
1160 for the following home leave days in addition to the
1161 eighty-four-day limitation: Christmas, the day before Christmas,
1162 the day after Christmas, Thanksgiving, the day before Thanksgiving
1163 and the day after Thanksgiving. However, before payment may be
1164 made for more than eighteen (18) home leave days in a year for a
1165 patient, the patient must have written authorization from a
1166 physician stating that the patient is physically and mentally able
1167 to be away from the facility on home leave. Such authorization
1168 must be filed with the division before it will be effective, and
1169 the authorization shall be effective for three (3) months from the
1170 date it is received by the division, unless it is revoked earlier
1171 by the physician because of a change in the condition of the
1172 patient.
1173 (b) All state-owned intermediate care facilities for
1174 the mentally retarded shall be reimbursed on a full reasonable
1175 cost basis.
1176 (13) Family planning services, including drugs, supplies and
1177 devices, when such services are under the supervision of a
1178 physician.
1179 (14) Clinic services. Such diagnostic, preventive,
1180 therapeutic, rehabilitative or palliative services furnished to an
1181 outpatient by or under the supervision of a physician or dentist
1182 in a facility which is not a part of a hospital but which is
1183 organized and operated to provide medical care to outpatients.

1184 Clinic services shall include any services reimbursed as
1185 outpatient hospital services which may be rendered in such a
1186 facility, including those that become so after July 1, 1991. On
1187 July 1, 1999, all fees for physicians' services reimbursed under
1188 authority of this paragraph (14) shall be reimbursed at ninety
1189 percent (90%) of the rate established on January 1, 1999, and as
1190 adjusted each January thereafter, under Medicare (Title XVIII of
1191 the Social Security Act), as amended, and which shall in no event
1192 be less than seventy percent (70%) of the rate established on
1193 January 1, 1994. All fees for physicians' services that are
1194 covered by both Medicare and Medicaid shall be reimbursed at ten
1195 percent (10%) of the adjusted Medicare payment established on
1196 January 1, 1999, and as adjusted each January thereafter, under
1197 Medicare (Title XVIII of the Social Security Act), as amended, and
1198 which shall in no event be less than seven percent (7%) of the
1199 adjusted Medicare payment established on January 1, 1994. On July
1200 1, 1999, all fees for dentists' services reimbursed under
1201 authority of this paragraph (14) shall be increased to one hundred
1202 sixty percent (160%) of the amount of the reimbursement rate that
1203 was in effect on June 30, 1999.
1204 (15) Home- and community-based services, as provided under
1205 Title XIX of the federal Social Security Act, as amended, under
1206 waivers, subject to the availability of funds specifically
1207 appropriated therefor by the Legislature. Payment for such
1208 services shall be limited to individuals who would be eligible for
1209 and would otherwise require the level of care provided in a
1210 nursing facility. The home- and community-based services
1211 authorized under this paragraph shall be expanded over a five-year
1212 period beginning July 1, 1999. The division shall certify case
1213 management agencies to provide case management services and
1214 provide for home- and community-based services for eligible
1215 individuals under this paragraph. The home- and community-based
1216 services under this paragraph and the activities performed by

1217 certified case management agencies under this paragraph shall be
1218 funded using state funds that are provided from the appropriation
1219 to the Division of Medicaid and used to match federal funds.
1220 (16) Mental health services. Approved therapeutic and case
1221 management services provided by (a) an approved regional mental
1222 health/retardation center established under Sections 41-19-31
1223 through 41-19-39, or by another community mental health service
1224 provider meeting the requirements of the Department of Mental
1225 Health to be an approved mental health/retardation center if
1226 determined necessary by the Department of Mental Health, using
1227 state funds which are provided from the appropriation to the State
1228 Department of Mental Health and used to match federal funds under
1229 a cooperative agreement between the division and the department,
1230 or (b) a facility which is certified by the State Department of
1231 Mental Health to provide therapeutic and case management services,
1232 to be reimbursed on a fee for service basis. Any such services
1233 provided by a facility described in paragraph (b) must have the
1234 prior approval of the division to be reimbursable under this
1235 section. After June 30, 1997, mental health services provided by
1236 regional mental health/retardation centers established under
1237 Sections 41-19-31 through 41-19-39, or by hospitals as defined in
1238 Section 41-9-3(a) and/or their subsidiaries and divisions, or by
1239 psychiatric residential treatment facilities as defined in Section
1240 43-11-1, or by another community mental health service provider
1241 meeting the requirements of the Department of Mental Health to be
1242 an approved mental health/retardation center if determined
1243 necessary by the Department of Mental Health, shall not be
1244 included in or provided under any capitated managed care pilot
1245 program provided for under paragraph (24) of this section.
1246 (17) Durable medical equipment services and medical supplies
1247 restricted to patients receiving home health services unless
1248 waived on an individual basis by the division. The division shall
1249 not expend more than Three Hundred Thousand Dollars ($300,000.00)

1250 of state funds annually to pay for medical supplies authorized
1251 under this paragraph.
1252 (18) Notwithstanding any other provision of this section to
1253 the contrary, the division shall make additional reimbursement to
1254 hospitals which serve a disproportionate share of low-income
1255 patients and which meet the federal requirements for such payments
1256 as provided in Section 1923 of the federal Social Security Act and
1257 any applicable regulations.
1258 (19) (a) Perinatal risk management services. The division
1259 shall promulgate regulations to be effective from and after
1260 October 1, 1988, to establish a comprehensive perinatal system for
1261 risk assessment of all pregnant and infant Medicaid recipients and
1262 for management, education and follow-up for those who are
1263 determined to be at risk. Services to be performed include case
1264 management, nutrition assessment/counseling, psychosocial
1265 assessment/counseling and health education. The division shall
1266 set reimbursement rates for providers in conjunction with the
1267 State Department of Health.
1268 (b) Early intervention system services. The division
1269 shall cooperate with the State Department of Health, acting as
1270 lead agency, in the development and implementation of a statewide
1271 system of delivery of early intervention services, pursuant to
1272 Part H of the Individuals with Disabilities Education Act (IDEA).
1273 The State Department of Health shall certify annually in writing
1274 to the director of the division the dollar amount of state early
1275 intervention funds available which shall be utilized as a
1276 certified match for Medicaid matching funds. Those funds then
1277 shall be used to provide expanded targeted case management
1278 services for Medicaid eligible children with special needs who are
1279 eligible for the state's early intervention system.
1280 Qualifications for persons providing service coordination shall be
1281 determined by the State Department of Health and the Division of
1282 Medicaid.

1283 (20) Home- and community-based services for physically
1284 disabled approved services as allowed by a waiver from the United
1285 States Department of Health and Human Services for home- and
1286 community-based services for physically disabled people using
1287 state funds which are provided from the appropriation to the State
1288 Department of Rehabilitation Services and used to match federal
1289 funds under a cooperative agreement between the division and the
1290 department, provided that funds for these services are
1291 specifically appropriated to the Department of Rehabilitation
1292 Services.
1293 (21) Nurse practitioner services. Services furnished by a
1294 registered nurse who is licensed and certified by the Mississippi
1295 Board of Nursing as a nurse practitioner including, but not
1296 limited to, nurse anesthetists, nurse midwives, family nurse
1297 practitioners, family planning nurse practitioners, pediatric
1298 nurse practitioners, obstetrics-gynecology nurse practitioners and
1299 neonatal nurse practitioners, under regulations adopted by the
1300 division. Reimbursement for such services shall not exceed ninety
1301 percent (90%) of the reimbursement rate for comparable services
1302 rendered by a physician.
1303 (22) Ambulatory services delivered in federally qualified
1304 health centers and in clinics of the local health departments of
1305 the State Department of Health for individuals eligible for
1306 medical assistance under this article based on reasonable costs as
1307 determined by the division.
1308 (23) Inpatient psychiatric services. Inpatient psychiatric
1309 services to be determined by the division for recipients under age
1310 twenty-one (21) which are provided under the direction of a
1311 physician in an inpatient program in a licensed acute care
1312 psychiatric facility or in a licensed psychiatric residential
1313 treatment facility, before the recipient reaches age twenty-one
1314 (21) or, if the recipient was receiving the services immediately
1315 before he reached age twenty-one (21), before the earlier of the

1316 date he no longer requires the services or the date he reaches age
1317 twenty-two (22), as provided by federal regulations. Recipients
1318 shall be allowed forty-five (45) days per year of psychiatric
1319 services provided in acute care psychiatric facilities, and shall
1320 be allowed unlimited days of psychiatric services provided in
1321 licensed psychiatric residential treatment facilities.
1322 (24) Managed care services in a program to be developed by
1323 the division by a public or private provider. Notwithstanding any
1324 other provision in this article to the contrary, the division
1325 shall establish rates of reimbursement to providers rendering care
1326 and services authorized under this section, and may revise such
1327 rates of reimbursement without amendment to this section by the
1328 Legislature for the purpose of achieving effective and accessible
1329 health services, and for responsible containment of costs. This
1330 shall include, but not be limited to, one (1) module of capitated
1331 managed care in a rural area, and one (1) module of capitated
1332 managed care in an urban area.
1333 (25) Birthing center services.
1334 (26) Hospice care. As used in this paragraph, the term
1335 "hospice care" means a coordinated program of active professional
1336 medical attention within the home and outpatient and inpatient
1337 care which treats the terminally ill patient and family as a unit,
1338 employing a medically directed interdisciplinary team. The
1339 program provides relief of severe pain or other physical symptoms
1340 and supportive care to meet the special needs arising out of
1341 physical, psychological, spiritual, social and economic stresses
1342 which are experienced during the final stages of illness and
1343 during dying and bereavement and meets the Medicare requirements
1344 for participation as a hospice as provided in 42 CFR Part 418.
1345 (27) Group health plan premiums and cost sharing if it is
1346 cost effective as defined by the Secretary of Health and Human
1347 Services.
1348 (28) Other health insurance premiums which are cost

1349 effective as defined by the Secretary of Health and Human
1350 Services. Medicare eligible must have Medicare Part B before
1351 other insurance premiums can be paid.
1352 (29) The Division of Medicaid may apply for a waiver from
1353 the Department of Health and Human Services for home- and
1354 community-based services for developmentally disabled people using
1355 state funds which are provided from the appropriation to the State
1356 Department of Mental Health and used to match federal funds under
1357 a cooperative agreement between the division and the department,
1358 provided that funds for these services are specifically
1359 appropriated to the Department of Mental Health.
1360 (30) Pediatric skilled nursing services for eligible persons
1361 under twenty-one (21) years of age.
1362 (31) Targeted case management services for children with
1363 special needs, under waivers from the United States Department of
1364 Health and Human Services, using state funds that are provided
1365 from the appropriation to the Mississippi Department of Human
1366 Services and used to match federal funds under a cooperative
1367 agreement between the division and the department.
1368 (32) Care and services provided in Christian Science
1369 Sanatoria operated by or listed and certified by The First Church
1370 of Christ Scientist, Boston, Massachusetts, rendered in connection
1371 with treatment by prayer or spiritual means to the extent that
1372 such services are subject to reimbursement under Section 1903 of
1373 the Social Security Act.
1374 (33) Podiatrist services.
1375 (34) Personal care services provided in a pilot program to
1376 not more than forty (40) residents at a location or locations to
1377 be determined by the division and delivered by individuals
1378 qualified to provide such services, as allowed by waivers under
1379 Title XIX of the Social Security Act, as amended. The division
1380 shall not expend more than Three Hundred Thousand Dollars
1381 ($300,000.00) annually to provide such personal care services.

1382 The division shall develop recommendations for the effective
1383 regulation of any facilities that would provide personal care
1384 services which may become eligible for Medicaid reimbursement
1385 under this section, and shall present such recommendations with
1386 any proposed legislation to the 1996 Regular Session of the
1387 Legislature on or before January 1, 1996.
1388 (35) Services and activities authorized in Sections
1389 43-27-101 and 43-27-103, using state funds that are provided from
1390 the appropriation to the State Department of Human Services and
1391 used to match federal funds under a cooperative agreement between
1392 the division and the department.
1393 (36) Nonemergency transportation services for
1394 Medicaid-eligible persons, to be provided by the Department of
1395 Human Services. The division may contract with additional
1396 entities to administer nonemergency transportation services as it
1397 deems necessary. All providers shall have a valid driver's
1398 license, vehicle inspection sticker and a standard liability
1399 insurance policy covering the vehicle.
1400 (37) Targeted case management services for individuals with
1401 chronic diseases, with expanded eligibility to cover services to
1402 uninsured recipients, on a pilot program basis. This paragraph
1403 (37) shall be contingent upon continued receipt of special funds
1404 from the Health Care Financing Authority and private foundations
1405 who have granted funds for planning these services. No funding
1406 for these services shall be provided from state general funds.
1407 (38) Chiropractic services: a chiropractor's manual
1408 manipulation of the spine to correct a subluxation, if x-ray
1409 demonstrates that a subluxation exists and if the subluxation has
1410 resulted in a neuromusculoskeletal condition for which
1411 manipulation is appropriate treatment. Reimbursement for
1412 chiropractic services shall not exceed Seven Hundred Dollars
1413 ($700.00) per year per recipient.
1414 Notwithstanding any provision of this article, except as

1415 authorized in the following paragraph and in Section 43-13-139,
1416 neither (a) the limitations on quantity or frequency of use of or
1417 the fees or charges for any of the care or services available to
1418 recipients under this section, nor (b) the payments or rates of
1419 reimbursement to providers rendering care or services authorized
1420 under this section to recipients, may be increased, decreased or
1421 otherwise changed from the levels in effect on July 1, 1986,
1422 unless such is authorized by an amendment to this section by the
1423 Legislature. However, the restriction in this paragraph shall not
1424 prevent the division from changing the payments or rates of
1425 reimbursement to providers without an amendment to this section
1426 whenever such changes are required by federal law or regulation,
1427 or whenever such changes are necessary to correct administrative
1428 errors or omissions in calculating such payments or rates of
1429 reimbursement.
1430 Notwithstanding any provision of this article, no new groups
1431 or categories of recipients and new types of care and services may
1432 be added without enabling legislation from the Mississippi
1433 Legislature, except that the division may authorize such changes
1434 without enabling legislation when such addition of recipients or
1435 services is ordered by a court of proper authority. The director
1436 shall keep the Governor advised on a timely basis of the funds
1437 available for expenditure and the projected expenditures. In the
1438 event current or projected expenditures can be reasonably
1439 anticipated to exceed the amounts appropriated for any fiscal
1440 year, the Governor, after consultation with the director, shall
1441 discontinue any or all of the payment of the types of care and
1442 services as provided herein which are deemed to be optional
1443 services under Title XIX of the federal Social Security Act, as
1444 amended, for any period necessary to not exceed appropriated
1445 funds, and when necessary shall institute any other cost
1446 containment measures on any program or programs authorized under
1447 the article to the extent allowed under the federal law governing

1448 such program or programs, it being the intent of the Legislature
1449 that expenditures during any fiscal year shall not exceed the
1450 amounts appropriated for such fiscal year.
1451 SECTION 11. Section 43-13-118, Mississippi Code of 1972, is
1452 brought forward as follows:[RF11]
1453 43-13-118. It shall be the duty of each provider
1454 participating in the medical assistance program to keep and
1455 maintain books, documents, and other records as prescribed by the
1456 division of Medicaid in substantiation of its claim for services
1457 rendered Medicaid recipients, and such books, documents, and other
1458 records shall be kept and maintained for a period of five (5)
1459 years or for whatever longer period as may be required or
1460 prescribed under federal or state statutes and shall be subject to
1461 audit by the division. The division shall be entitled to full
1462 recoupment of the amount it has paid any provider of medical
1463 service who has failed to keep or maintain records as required
1464 herein.
1465 SECTION 12. Section 43-13-120, Mississippi Code of 1972, is
1466 brought forward as follows:[RF12]
1467 43-13-120. (1) Any person who is a Medicaid recipient and
1468 is receiving medical assistance for services provided in a
1469 long-term care facility under the provisions of Section 43-13-117
1470 from the Division of Medicaid in the Office of the Governor, who
1471 dies intestate and leaves no known heirs, shall have deemed,
1472 through his acceptance of such medical assistance, the Division of
1473 Medicaid as his beneficiary to all such funds in an amount not to
1474 exceed Two Hundred Fifty Dollars ($250.00) which are in his
1475 possession at the time of his death. Such funds, together with
1476 any accrued interest thereon, shall be reported by the long-term
1477 care facility to the State Treasurer in the manner provided in
1478 subsection (2).
1479 (2) The report of such funds shall be verified, shall be on
1480 a form prescribed or approved by the Treasurer, and shall include

1481 (a) the name of the deceased person and his last known address
1482 prior to entering the long-term care facility; (b) the name and
1483 last known address of each person who may possess an interest in
1484 such funds; and (c) any other information which the Treasurer
1485 prescribes by regulation as necessary for the administration of
1486 this section. The report shall be filed with the Treasurer prior
1487 to November 1 of each year in which the long-term care facility
1488 has provided services to a person or persons having funds to which
1489 this section applies.

1490 (3) Within one hundred twenty (120) days from November 1 of
1491 each year in which a report is made pursuant to subsection (2),
1492 the Treasurer shall cause notice to be published in a newspaper
1493 having general circulation in the county of this state in which is
1494 located the last known address of the person or persons named in
1495 the report who may possess an interest in such funds, or if no
1496 such person is named in the report, in the county in which is
1497 located the last known address of the deceased person prior to
1498 entering the long-term care facility. If no address is given in
1499 the report or if the address is outside of this state, the notice
1500 shall be published in a newspaper having general circulation in
1501 the county in which the facility is located. The notice shall
1502 contain (a) the name of the deceased person; (b) his last known
1503 address prior to entering the facility; (c) the name and last
1504 known address of each person named in the report who may possess
1505 an interest in such funds; and (d) a statement that any person
1506 possessing an interest in such funds must make a claim therefor to
1507 the Treasurer within ninety (90) days after such publication date
1508 or the funds will become the property of the State of Mississippi.
1509 In any year in which the Treasurer publishes a notice of
1510 abandoned property under Section 89-12-27, the Treasurer may
1511 combine the notice required by this section with the notice of
1512 abandoned property. The cost to the Treasurer of publishing the
1513 notice required by this section shall be paid by the Division of

1514 Medicaid.

1515 (4) Each long-term care facility that makes a report of
1516 funds of a deceased person under this section shall pay over and
1517 deliver such funds, together with any accrued interest thereon, to
1518 the Treasurer not later than ten (10) days after notice of such
1519 funds has been published by the Treasurer as provided in
1520 subsection (3). If a claim to such funds is not made by any
1521 person having an interest therein within ninety (90) days of the
1522 published notice, the Treasurer shall place such funds in the
1523 special account in the State Treasury to the credit of the
1524 "Governor's Office - Division of Medicaid" to be expended by the
1525 Division of Medicaid for the purposes provided under Mississippi
1526 Medicaid Law.

1527 (5) This section shall not be applicable to any Medicaid
1528 patient in a long-term care facility of a state institution listed
1529 in Section 41-7-73, who has a personal deposit fund as provided
1530 for in Section 41-7-90.

1531 SECTION 13. Section 43-13-121, Mississippi Code of 1972, is
1532 brought forward as follows:[RF13]

1533 43-13-121. (1) The division is authorized and empowered to
1534 administer a program of medical assistance under the provisions of
1535 this article, and to do the following:

1536 (a) Adopt and promulgate reasonable rules, regulations
1537 and standards, with approval of the Governor:

1538 (i) Establishing methods and procedures as may be
1539 necessary for the proper and efficient administration of this
1540 article;

1541 (ii) Providing medical assistance to all qualified
1542 recipients under the provisions of this article as the division
1543 may determine and within the limits of appropriated funds;

1544 (iii) Establishing reasonable fees, charges and
1545 rates for medical services and drugs; and in doing so shall fix
1546 all such fees, charges and rates at the minimum levels absolutely

1547 necessary to provide the medical assistance authorized by this
1548 article, and shall not change any such fees, charges or rates
1549 except as may be authorized in Section 43-13-117;
1550 (iv) Providing for fair and impartial hearings;
1551 (v) Providing safeguards for preserving the
1552 confidentiality of records; and
1553 (vi) For detecting and processing fraudulent
1554 practices and abuses of the program;
1555 (b) Receive and expend state, federal and other funds
1556 in accordance with court judgments or settlements and agreements
1557 between the State of Mississippi and the federal government, the
1558 rules and regulations promulgated by the division, with the
1559 approval of the Governor, and within the limitations and
1560 restrictions of this article and within the limits of funds
1561 available for such purpose;
1562 (c) Subject to the limits imposed by this article, to
1563 submit a plan for medical assistance to the federal Department of
1564 Health and Human Services for approval pursuant to the provisions
1565 of the Social Security Act, to act for the state in making
1566 negotiations relative to the submission and approval of such plan,
1567 to make such arrangements, not inconsistent with the law, as may
1568 be required by or pursuant to federal law to obtain and retain
1569 such approval and to secure for the state the benefits of the
1570 provisions of such law;
1571 No agreements, specifically including the general plan for
1572 the operation of the Medicaid program in this state, shall be made
1573 by and between the division and the Department of Health and Human
1574 Services unless the Attorney General of the State of Mississippi
1575 has reviewed said agreements, specifically including said
1576 operational plan, and has certified in writing to the Governor and
1577 to the director of the division that said agreements, including
1578 said plan of operation, have been drawn strictly in accordance
1579 with the terms and requirements of this article;

1580 (d) Pursuant to the purposes and intent of this article
1581 and in compliance with its provisions, provide for aged persons
1582 otherwise eligible the benefits provided under Title XVIII of the
1583 federal Social Security Act by expenditure of funds available for
1584 such purposes;
1585 (e) To make reports to the federal Department of Health
1586 and Human Services as from time to time may be required by such
1587 federal department and to the Mississippi Legislature as
1588 hereinafter provided;
1589 (f) Define and determine the scope, duration and amount
1590 of medical assistance which may be provided in accordance with
1591 this article and establish priorities therefor in conformity with
1592 this article;
1593 (g) Cooperate and contract with other state agencies
1594 for the purpose of coordinating medical assistance rendered under
1595 this article and eliminating duplication and inefficiency in the
1596 program;
1597 (h) Adopt and use an official seal of the division;
1598 (i) Sue in its own name on behalf of the State of
1599 Mississippi and employ legal counsel on a contingency basis with
1600 the approval of the Attorney General;
1601 (j) To recover any and all payments incorrectly made by
1602 the division or by the Medicaid Commission to a recipient or
1603 provider from the recipient or provider receiving said payments;
1604 (k) To recover any and all payments by the division or
1605 by the Medicaid Commission fraudulently obtained by a recipient or
1606 provider. Additionally, if recovery of any payments fraudulently
1607 obtained by a recipient or provider is made in any court, then,
1608 upon motion of the Governor, the judge of said court may award
1609 twice the payments recovered as damages;
1610 (l) Have full, complete and plenary power and authority
1611 to conduct such investigations as it may deem necessary and
1612 requisite of alleged or suspected violations or abuses of the

1613 provisions of this article or of the regulations adopted hereunder
1614 including, but not limited to, fraudulent or unlawful act or deed
1615 by applicants for medical assistance or other benefits, or
1616 payments made to any person, firm or corporation under the terms,
1617 conditions and authority of this article, to suspend or disqualify
1618 any provider of services, applicant or recipient for gross abuse,
1619 fraudulent or unlawful acts for such periods, including
1620 permanently, and under such conditions as the division may deem
1621 proper and just, including the imposition of a legal rate of
1622 interest on the amount improperly or incorrectly paid. Should an
1623 administrative hearing become necessary, the division shall be
1624 authorized, should the provider not succeed in his defense, in
1625 taxing the costs of the administrative hearing, including the
1626 costs of the court reporter or stenographer and transcript, to the
1627 provider. The convictions of a recipient or a provider in a state
1628 or federal court for abuse, fraudulent or unlawful acts under this
1629 chapter shall constitute an automatic disqualification of the
1630 recipient or automatic disqualification of the provider from
1631 participation under the Medicaid program.
1632 A conviction, for the purposes of this chapter, shall include
1633 a judgment entered on a plea of nolo contendere or a
1634 nonadjudicated guilty plea and shall have the same force as a
1635 judgment entered pursuant to a guilty plea or a conviction
1636 following trial. A certified copy of the judgment of the court of
1637 competent jurisdiction of such conviction shall constitute prima
1638 facie evidence of such conviction for disqualification purposes.
1639 (m) Establish and provide such methods of
1640 administration as may be necessary for the proper and efficient
1641 operation of the program, fully utilizing computer equipment as
1642 may be necessary to oversee and control all current expenditures
1643 for purposes of this article, and to closely monitor and supervise
1644 all recipient payments and vendors rendering such services
1645 hereunder; and

1646 (n) To cooperate and contract with the federal
1647 government for the purpose of providing medical assistance to
1648 Vietnamese and Cambodian refugees, pursuant to the provisions of
1649 Public Law 94-23 and Public Law 94-24, including any amendments
1650 thereto, only to the extent that such assistance and the
1651 administrative cost related thereto are one hundred percent (100%)
1652 reimbursable by the federal government. For the purposes of
1653 Section 43-13-117, persons receiving medical assistance pursuant
1654 to Public Law 94-23 and Public Law 94-24, including any amendments
1655 thereto, shall not be considered a new group or category of
1656 recipient.
1657 (2) The division also shall exercise such additional powers
1658 and perform such other duties as may be conferred upon the
1659 division by act of the Legislature hereafter.
1660 (3) The division, and the State Department of Health as the
1661 agency for licensure of health care facilities and certification
1662 and inspection for the Medicaid and/or Medicare programs, shall
1663 contract for or otherwise provide for the consolidation of on-site
1664 inspections of health care facilities which are necessitated by
1665 the respective programs and functions of the division and the
1666 department.
1667 (4) The division and its hearing officers shall have power
1668 to preserve and enforce order during hearings; to issue subpoenas
1669 for, to administer oaths to and to compel the attendance and
1670 testimony of witnesses, or the production of books, papers,
1671 documents and other evidence, or the taking of depositions before
1672 any designated individual competent to administer oaths; to
1673 examine witnesses; and to do all things conformable to law which
1674 may be necessary to enable them effectively to discharge the
1675 duties of their office. In compelling the attendance and
1676 testimony of witnesses, or the production of books, papers,
1677 documents and other evidence, or the taking of depositions, as
1678 authorized by this section, the division or its hearing officers

1679 may designate an individual employed by the division or some other
1680 suitable person to execute and return such process, whose action
1681 in executing and returning such process shall be as lawful as if
1682 done by the sheriff or some other proper officer authorized to
1683 execute and return process in the county where the witness may
1684 reside. In carrying out the investigatory powers under the
1685 provisions of this article, the director or other designated
1686 person or persons shall be authorized to examine, obtain, copy or
1687 reproduce the books, papers, documents, medical charts,
1688 prescriptions and other records relating to medical care and
1689 services furnished by said provider to a recipient or designated
1690 recipients of Medicaid services under investigation. In the
1691 absence of the voluntary submission of said books, papers,
1692 documents, medical charts, prescriptions and other records, the
1693 Governor, the director, or other designated person shall be
1694 authorized to issue and serve subpoenas instantly upon such
1695 provider, his agent, servant or employee for the production of
1696 said books, papers, documents, medical charts, prescriptions or
1697 other records during an audit or investigation of said provider.
1698 If any provider or his agent, servant or employee should refuse to
1699 produce said records after being duly subpoenaed, the director
1700 shall be authorized to certify such facts and institute contempt
1701 proceedings in the manner, time, and place as authorized by law
1702 for administrative proceedings. As an additional remedy, the
1703 division shall be authorized to recover all amounts paid to said
1704 provider covering the period of the audit or investigation,
1705 inclusive of a legal rate of interest and a reasonable attorney's
1706 fee and costs of court if suit becomes necessary.
1707 (5) If any person in proceedings before the division
1708 disobeys or resists any lawful order or process, or misbehaves
1709 during a hearing or so near the place thereof as to obstruct the
1710 same, or neglects to produce, after having been ordered to do so,
1711 any pertinent book, paper or document, or refuses to appear after

1712 having been subpoenaed, or upon appearing refuses to take the oath
1713 as a witness, or after having taken the oath refuses to be
1714 examined according to law, the director shall certify the facts to
1715 any court having jurisdiction in the place in which it is sitting,
1716 and the court shall thereupon, in a summary manner, hear the
1717 evidence as to the acts complained of, and if the evidence so
1718 warrants, punish such person in the same manner and to the same
1719 extent as for a contempt committed before the court, or commit
1720 such person upon the same condition as if the doing of the
1721 forbidden act had occurred with reference to the process of, or in
1722 the presence of, the court.
1723 (6) In suspending or terminating any provider from
1724 participation in the Medicaid program, the division shall preclude
1725 such provider from submitting claims for payment, either
1726 personally or through any clinic, group, corporation or other
1727 association to the division or its fiscal agents for any services
1728 or supplies provided under the Medicaid program except for those
1729 services or supplies provided prior to the suspension or
1730 termination. No clinic, group, corporation or other association
1731 which is a provider of services shall submit claims for payment to
1732 the division or its fiscal agents for any services or supplies
1733 provided by a person within such organization who has been
1734 suspended or terminated from participation in the Medicaid program
1735 except for those services or supplies provided prior to the
1736 suspension or termination. When said provision is violated by a
1737 provider of services which is a clinic, group, corporation or
1738 other association, the division may suspend or terminate such
1739 organization from participation. Suspension may be applied by the
1740 division to all known affiliates of a provider, provided that each
1741 decision to include an affiliate is made on a case by case basis
1742 after giving due regard to all relevant facts and circumstances.
1743 The violation, failure, or inadequacy of performance may be
1744 imputed to a person with whom the provider is affiliated where

1745 such conduct was accomplished with the course of his official duty
1746 or was effectuated by him with the knowledge or approval of such
1747 person.
1748 SECTION 14. Section 43-13-122, Mississippi Code of 1972, is
1749 brought forward as follows:[RF14]
1750 43-13-122. (1) The division is authorized to apply to the
1751 Health Care Financing Administration of the United States
1752 Department of Health and Human Services for waivers and research
1753 and demonstration grants in the following programs:
1754 A multistate demonstration integrating case-mix payment and
1755 quality monitoring system in nursing facilities grant to develop
1756 and implement a resident assessment and a quality monitoring
1757 system and a nursing facility reimbursement plan based on
1758 case-mix. This subsection authorizes only the participation by
1759 the division in the demonstration described herein.
1760 (2) The division shall implement the integrated case-mix
1761 payment and quality monitoring system developed in subsection (1)
1762 of this section, which includes the fair rental system for
1763 property costs and in which recapture of depreciation is
1764 eliminated. The division may revise the reimbursement methodology
1765 for the case-mix payment system by reducing payment for hospital
1766 leave and therapeutic home leave days to the lowest case mix
1767 category for nursing facilities, modifying the current method of
1768 scoring residents so that only services provided at the nursing
1769 facility are considered in calculating a facility's per diem, and
1770 the division may limit administrative and operating costs, but in
1771 no case shall these costs be less than one hundred nine percent
1772 (109%) of the median administrative and operating costs for each
1773 class of facility, not to exceed the median used to calculate the
1774 nursing facility reimbursement for fiscal year 1996, to be applied
1775 uniformly to all long-term care facilities. This subsection (2)
1776 shall stand repealed on July 1, 1997.
1777 (3) The division is further authorized to accept and expend

1778 any grants, donations or contributions from any public or private
1779 organization together with any additional federal matching funds
1780 that may accrue and including, but not limited to, one hundred
1781 percent (100%) federal grant funds or funds from any governmental
1782 entity or instrumentality thereof in furthering the purposes and
1783 objectives of the Mississippi Medicaid program, provided that such
1784 receipts and expenditures are reported and otherwise handled in
1785 accordance with the General Fund Stabilization Act. The
1786 Department of Finance and Administration is authorized to transfer
1787 monies to the division from special funds in the State Treasury in
1788 amounts not exceeding the amounts authorized in the appropriation
1789 to the division.

1790 SECTION 15. Section 43-13-123, Mississippi Code of 1972, is
1791 brought forward as follows:[RF15]

1792 43-13-123. The determination of the method of providing
1793 payment of claims under this article shall be made by the
1794 division, with approval of the Governor, which methods may be:

1795 (1) By contract with insurance companies licensed to do
1796 business in the State of Mississippi or with nonprofit hospital
1797 service corporations, medical or dental service corporations,
1798 authorized to do business in Mississippi to underwrite on an
1799 insured premium approach, such medical assistance benefits as may
1800 be available, and any carrier selected pursuant to the provisions
1801 of this article is hereby expressly authorized and empowered to
1802 undertake the performance of the requirements of such contract.

1803 (2) By contract with an insurance company licensed to do
1804 business in the State of Mississippi or with nonprofit hospital
1805 service, medical or dental service organizations, or other
1806 organizations including data processing companies, authorized to
1807 do business in Mississippi to act as fiscal agent.

1808 The division shall solicit, receive, review, accept and award
1809 contracts for services to be provided under either of the
1810 above-described provisions after advertising for bids by

1811 publication of notice therefor in one or more newspapers having a
1812 general circulation in the State of Mississippi, which said notice
1813 shall be published for at least once a week for three (3)
1814 consecutive weeks, the first publication of which shall be at
1815 least twenty-one (21) days prior to the date set therein for the
1816 receipt of bids. Final determination on acceptance of a bid for
1817 the purposes of this provision will be subject to the review and
1818 approval of the Public Procurement Review Board.
1819 The authorization of the foregoing methods shall not preclude
1820 other methods of providing payment claims through direct operation
1821 of the program by the state or its agencies.
1822 SECTION 16. Section 43-13-125, Mississippi Code of 1972, is
1823 brought forward as follows:[RF16]
1824 43-13-125. (1) If medical assistance is provided to a
1825 recipient under this article for injuries, disease or sickness
1826 caused under circumstances creating a cause of action in favor of
1827 the recipient against any person, firm or corporation, then the
1828 division shall be entitled to recover the proceeds that may result
1829 from the exercise of any rights of recovery which the recipient
1830 may have against any such person, firm or corporation to the
1831 extent of the actual amount of the medical assistance payments
1832 made by the Division of Medicaid on behalf of the recipient. The
1833 recipient shall execute and deliver instruments and papers to do
1834 whatever is necessary to secure such rights and shall do nothing
1835 after said medical assistance is provided to prejudice the
1836 subrogation rights of the division. Court orders or agreements
1837 for reimbursement of Medicaid payments shall direct such payments
1838 to the Division of Medicaid, which shall be authorized to endorse
1839 any and all checks, drafts, money orders, or other negotiable
1840 instruments representing Medicaid payment recoveries that are
1841 received.
1842 The division, with the approval of the Governor, may
1843 compromise or settle any such claim and execute a release of any

1844 claim it has by virtue of this section.

1845 (2) The acceptance of medical assistance under this article
1846 or the making of a claim thereunder shall not affect the right of
1847 a recipient or his legal representative to recover the medical
1848 assistance payments made by the division as an element of special
1849 damages in any action at law; provided, however, that a copy of
1850 the pleadings shall be certified to the division at the time of
1851 the institution of suit, and proof of such notice shall be filed
1852 of record in such action. The division may, at any time before
1853 the trial on the facts, join in such action or may intervene
1854 therein. Any amount recovered by a recipient or his legal
1855 representative shall be applied as follows:

1856 (a) The reasonable costs of the collection, including
1857 attorney's fees, as approved and allowed by the court in which
1858 such action is pending, or in case of settlement without suit, by
1859 the legal representative of the division;

1860 (b) The actual amount of the medical assistance
1861 payments made by the division on behalf of the recipient; or such
1862 pro rata amount as may be arrived at by the legal representative
1863 of the division and the recipient's attorney, or as set by the
1864 court having jurisdiction; and

1865 (c) Any excess shall be awarded to the recipient.

1866 (3) No compromise of any claim by the recipient or his legal
1867 representative shall be binding upon or affect the rights of the
1868 division against the third party unless the division, with the
1869 approval of the Governor, has entered into the compromise. Any
1870 compromise effected by the recipient or his legal representative
1871 with the third party in the absence of advance notification to and
1872 approved by the division shall constitute conclusive evidence of
1873 the liability of the third party, and the division, in litigating
1874 its claim against said third party, shall be required only to
1875 prove the amount and correctness of its claim relating to such
1876 injury, disease or sickness. It is further provided that should

1877 the recipient or his legal representative fail to notify the
1878 division of the institution of legal proceedings against a third
1879 party for which the division has a cause of action, the facts
1880 relating to negligence and the liability of the third party, if
1881 judgment is rendered for the recipient, shall constitute
1882 conclusive evidence of liability in a subsequent action maintained
1883 by the division and only the amount and correctness of the
1884 division's claim relating to injuries, disease or sickness shall
1885 be tried before the court. The division shall be authorized in
1886 bringing such action against the third party and his insurer
1887 jointly or against the insurer alone.

1888 (4) Nothing herein shall be construed to diminish or
1889 otherwise restrict the subrogation rights of the Division of
1890 Medicaid against a third party for medical assistance paid by the
1891 Division of Medicaid or the Medicaid Commission in behalf of the
1892 recipient as a result of injuries, disease or sickness caused
1893 under circumstances creating a cause of action in favor of the
1894 recipient against such a third party.

1895 (5) Any amounts recovered by the division under this section
1896 shall, by the division, be placed to the credit of the funds
1897 appropriated for benefits under this article proportionate to the
1898 amounts provided by the state and federal governments
1899 respectively.

1900 SECTION 17. Section 43-13-127, Mississippi Code of 1972, is
1901 brought forward as follows:[RF17]

1902 43-13-127. Within sixty (60) days after the end of each
1903 fiscal year and at each regular session of the Legislature, the
1904 division shall make and publish a report to the Governor and to
1905 the Legislature, showing for the period of time covered the
1906 following:

1907 (a) The total number of recipients;

1908 (b) The total amount paid for medical assistance and
1909 care under this article;

1910 (c) The total number of applications;
1911 (d) The number of applications approved;
1912 (e) The number of applications denied;
1913 (f) The amount expended for administration of the
1914 provisions of this article;
1915 (g) The amount of money received from the federal
1916 government, if any;
1917 (h) The amount of money recovered by reason of
1918 collections from third persons by reason of assignment or
1919 subrogation, and the disposition of the same;
1920 (i) The actions and activities of the division in
1921 detecting and investigating suspected or alleged fraudulent
1922 practices, violations and abuses of the program;
1923 (j) Any recommendations it may have as to expanding,
1924 enlarging, limiting or restricting, the eligibility of persons
1925 covered by this article or services provided by this article, to
1926 make more effective the basic purposes of this article; to
1927 eliminate or curtail fraudulent practices and inequities in the
1928 plan or administration thereof; and to continue to participate in
1929 receiving federal funds for the furnishing of medical assistance
1930 under Title XIX of the Social Security Act or other federal law.
1931 SECTION 18. Section 43-13-129, Mississippi Code of 1972, is
1932 brought forward as follows:[RF18]
1933 43-13-129. Any person making application for benefits under
1934 this article for himself or for another person, and any provider
1935 of services, who knowingly makes a false statement or false
1936 representation or fails to disclose a material fact to obtain or
1937 increase any benefit or payment under this article shall be guilty
1938 of a misdemeanor and, upon conviction thereof, shall be punished
1939 by a fine not to exceed Five Hundred Dollars ($500.00) or
1940 imprisoned not to exceed one (1) year, or by both such fine and
1941 imprisonment. Each false statement or false representation or
1942 failure to disclose a material fact shall constitute a separate

1943 offense. This section shall not prohibit prosecution under any
1944 other criminal statutes of this state or the United States.
1945 SECTION 19. Section 43-13-131, Mississippi Code of 1972, is
1946 brought forward as follows:[RF19]
1947 43-13-131. Any person who shall, through intentional
1948 misrepresentation, fraud, deceit or unlawful design, either acting
1949 individually or in concert with others, influence any recipient to
1950 elect any particular provider of services, or any particular type
1951 of services, for the purposes and with the intent to obtain or
1952 increase any benefit or payment under this article shall be guilty
1953 of a misdemeanor and, upon conviction thereof, shall be punished
1954 by a fine not exceeding Five Hundred Dollars ($500.00) or
1955 imprisonment not exceeding one (1) year, or by both such fine and
1956 imprisonment. This section shall not prohibit prosecution under
1957 any other criminal statutes of this state or the United States.
1958 SECTION 20. Section 43-13-133, Mississippi Code of 1972, is
1959 brought forward as follows:[RF20]
1960 43-13-133. It is the intent of the Legislature that all
1961 federal matching funds for medical assistance under Titles V,
1962 XVIII and XIX of the federal Social Security Act paid into any
1963 state health agency after the passage of this article shall be
1964 used exclusively to defray the cost of medical assistance expended
1965 under the terms of this article.
1966 SECTION 21. Section 43-13-137, Mississippi Code of 1972, is
1967 brought forward as follows:[RF21]
1968 43-13-137. Insofar as the provisions of this article are
1969 inconsistent with the provisions of any other law, general,
1970 special or local, the provisions of this article shall be
1971 controlling, including, without limitation, the provisions of
1972 Sections 25-43-1 through 25-43-19, Mississippi Code of 1972.
1973 SECTION 22. Section 43-13-139, Mississippi Code of 1972, is
1974 brought forward as follows:[RF22]
1975 43-13-139. Nothing contained in this article shall be

1976 construed to prevent the Governor, in his discretion, from
1977 discontinuing or limiting medical assistance to any individuals
1978 who are classified or deemed to be within any optional group or
1979 optional category of recipients as prescribed under Title XIX of
1980 the federal Social Security Act or the implementing federal
1981 regulations. If the Congress or the United States Department of
1982 Health and Human Services ceases to provide federal matching funds
1983 for any group or category of recipients or any type of care and
1984 services, the division shall cease state funding for such group or
1985 category or such type of care and services, notwithstanding any
1986 provision of this article.
1987 SECTION 23. This act shall take effect and be in force from
1988 and after July 1, 2000.