MISSISSIPPI LEGISLATURE REGULAR SESSION 2007

By: Representatives Dedeaux, Holland, Morris To: Medicaid

HOUSE BILL NO. 528

1 AN ACT TO BRING FORWARD SECTIONS 43-13-105, 43-13-107,
2 43-13-113, 43-13-115, 43-13-116, 43-13-117, 43-13-121, 43-13-122,
3 43-13-123, 43-13-125, 43-13-127, 43-13-129, 43-13-139, 43-13-143
4 AND 43-13-145, MISSISSIPPI CODE OF 1972, OF THE MISSISSIPPI
5 MEDICAID LAW, FOR THE PURPOSES OF AMENDMENT; AND FOR RELATED
6 PURPOSES.

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

8 **SECTION 1.** Section 43-13-105, Mississippi Code of 1972, is
9 brought forward as follows:

10 43-13-105. When used in this article, the following
11 definitions shall apply, unless the context requires otherwise:

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

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

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

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

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

26 (f) "State health agency" shall mean any agency,
27 department, institution, board or commission of the State of
28 Mississippi, except the University Medical School, which is
29 supported in whole or in part by any public funds, including funds

30 directly appropriated from the State Treasury, funds derived by
31 taxes, fees levied or collected by statutory authority, or any
32 other funds used by "state health agencies" derived from federal
33 sources, when any funds available to such agency are expended
34 either directly or indirectly in connection with, or in support
35 of, any public health, hospital, hospitalization or other public
36 programs for the preventive treatment or actual medical treatment
37 of persons who are physically or mentally ill or mentally
38 retarded.

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

43 **SECTION 2.** Section 43-13-107, Mississippi Code of 1972, is
44 brought forward as follows:

45 43-13-107. (1) The Division of Medicaid is created in the
46 Office of the Governor and established to administer this article
47 and perform such other duties as are prescribed by law.

48 (2) (a) The Governor shall appoint a full-time executive
49 director, with the advice and consent of the Senate, who shall be
50 either (i) a physician with administrative experience in a medical
51 care or health program, or (ii) a person holding a graduate degree
52 in medical care administration, public health, hospital
53 administration, or the equivalent, or (iii) a person holding a
54 bachelor's degree in business administration or hospital
55 administration, with at least ten (10) years' experience in
56 management-level administration of Medicaid programs. The
57 executive director shall be the official secretary and legal
58 custodian of the records of the division; shall be the agent of
59 the division for the purpose of receiving all service of process,
60 summons and notices directed to the division; and shall perform
61 such other duties as the Governor may prescribe from time to time.

62 (b) The Governor shall appoint a full-time Deputy
63 Director of Administration, with the advice and consent of the
64 Senate, who shall have at least a bachelor's degree from an
65 accredited college or university, and/or shall possess a special
66 knowledge of Medicaid as pertaining to the State of Mississippi.
67 The Deputy Director of Administration may perform those duties of
68 the executive director that the executive director has not
69 expressly retained for himself.
70 (c) The executive director and the Deputy Director of
71 Administration of the Division of Medicaid shall perform all other
72 duties that are now or may be imposed upon them by law.
73 (d) The terms of office of the executive director and
74 the Deputy Director of Administration shall be concurrent with the
75 terms of the Governor appointing them. In the event of a vacancy,
76 the same shall be filled by the Governor for the unexpired portion
77 of the term in which the vacancy occurs. However, the incumbent
78 executive director and Deputy Director of Administration shall
79 serve until the appointment and qualification of their successors.
80 (e) The executive director and the Deputy Director of
81 Administration shall, before entering upon the discharge of the
82 duties of their offices, take and subscribe to the oath of office
83 prescribed by the Constitution and shall file the same in the
84 Office of the Secretary of State, and each shall execute a bond in
85 some surety company authorized to do business in the state in the
86 penal sum of One Hundred Thousand Dollars ($100,000.00),
87 conditioned for the faithful and impartial discharge of the duties
88 of their offices. The premium on those bonds shall be paid as
89 provided by law out of funds appropriated to the Division of
90 Medicaid for contractual services.
91 (f) The executive director, with the approval of the
92 Governor and subject to the rules and regulations of the State
93 Personnel Board, shall employ such professional, administrative,
94 stenographic, secretarial, clerical and technical assistance as

95 may be necessary to perform the duties required in administering
96 this article and fix the compensation for those persons, all in
97 accordance with a state merit system meeting federal requirements.
98 When the salary of the executive director is not set by law, that
99 salary shall be set by the State Personnel Board. No employees of
100 the Division of Medicaid shall be considered to be staff members
101 of the immediate Office of the Governor; however, the provisions
102 of Section 25-9-107(c)(xv) shall apply to the executive director
103 and other administrative heads of the division.

104 (3) (a) There is established a Medical Care Advisory
105 Committee, which shall be the committee that is required by
106 federal regulation to advise the Division of Medicaid about health
107 and medical care services.

108 (b) The advisory committee shall consist of not less
109 than eleven (11) members, as follows:

110 (i) The Governor shall appoint five (5) members,
111 one (1) from each congressional district and one (1) from the
112 state at large;

113 (ii) The Lieutenant Governor shall appoint three
114 (3) members, one (1) from each Supreme Court district;

115 (iii) The Speaker of the House of Representatives
116 shall appoint three (3) members, one (1) from each Supreme Court
117 district.

118 All members appointed under this paragraph shall either be
119 health care providers or consumers of health care services. One
120 (1) member appointed by each of the appointing authorities shall
121 be a board certified physician.

122 (c) The respective Chairmen of the House Medicaid
123 Committee, the House Public Health and Human Services Committee,
124 the House Appropriations Committee, the Senate Public Health and
125 Welfare Committee and the Senate Appropriations Committee, or
126 their designees, two (2) members of the State Senate appointed by
127 the Lieutenant Governor and one (1) member of the House of

128 Representatives appointed by the Speaker of the House, shall serve
129 as ex officio nonvoting members of the advisory committee.
130 (d) In addition to the committee members required by
131 paragraph (b), the advisory committee shall consist of such other
132 members as are necessary to meet the requirements of the federal
133 regulation applicable to the advisory committee, who shall be
134 appointed as provided in the federal regulation.
135 (e) The chairmanship of the advisory committee shall
136 alternate for twelve-month periods between the Chairmen of the
137 House Medicaid Committee and the Senate Public Health and Welfare
138 Committee.
139 (f) The members of the advisory committee specified in
140 paragraph (b) shall serve for terms that are concurrent with the
141 terms of members of the Legislature, and any member appointed
142 under paragraph (b) may be reappointed to the advisory committee.
143 The members of the advisory committee specified in paragraph (b)
144 shall serve without compensation, but shall receive reimbursement
145 to defray actual expenses incurred in the performance of committee
146 business as authorized by law. Legislators shall receive per diem
147 and expenses, which may be paid from the contingent expense funds
148 of their respective houses in the same amounts as provided for
149 committee meetings when the Legislature is not in session.
150 (g) The advisory committee shall meet not less than
151 quarterly, and advisory committee members shall be furnished
152 written notice of the meetings at least ten (10) days before the
153 date of the meeting.
154 (h) The executive director shall submit to the advisory
155 committee all amendments, modifications and changes to the state
156 plan for the operation of the Medicaid program, for review by the
157 advisory committee before the amendments, modifications or changes
158 may be implemented by the division.
159 (i) The advisory committee, among its duties and
160 responsibilities, shall:

161 (i) Advise the division with respect to
162 amendments, modifications and changes to the state plan for the
163 operation of the Medicaid program;
164 (ii) Advise the division with respect to issues
165 concerning receipt and disbursement of funds and eligibility for
166 Medicaid;
167 (iii) Advise the division with respect to
168 determining the quantity, quality and extent of medical care
169 provided under this article;
170 (iv) Communicate the views of the medical care
171 professions to the division and communicate the views of the
172 division to the medical care professions;
173 (v) Gather information on reasons that medical
174 care providers do not participate in the Medicaid program and
175 changes that could be made in the program to encourage more
176 providers to participate in the Medicaid program, and advise the
177 division with respect to encouraging physicians and other medical
178 care providers to participate in the Medicaid program;
179 (vi) Provide a written report on or before
180 November 30 of each year to the Governor, Lieutenant Governor and
181 Speaker of the House of Representatives.
182 (4) (a) There is established a Drug Use Review Board, which
183 shall be the board that is required by federal law to:
184 (i) Review and initiate retrospective drug use,
185 review including ongoing periodic examination of claims data and
186 other records in order to identify patterns of fraud, abuse, gross
187 overuse, or inappropriate or medically unnecessary care, among
188 physicians, pharmacists and individuals receiving Medicaid
189 benefits or associated with specific drugs or groups of drugs.
190 (ii) Review and initiate ongoing interventions for
191 physicians and pharmacists, targeted toward therapy problems or
192 individuals identified in the course of retrospective drug use
193 reviews.

194 (iii) On an ongoing basis, assess data on drug use
195 against explicit predetermined standards using the compendia and
196 literature set forth in federal law and regulations.
197 (b) The board shall consist of not less than twelve
198 (12) members appointed by the Governor, or his designee.
199 (c) The board shall meet at least quarterly, and board
200 members shall be furnished written notice of the meetings at least
201 ten (10) days before the date of the meeting.
202 (d) The board meetings shall be open to the public,
203 members of the press, legislators and consumers. Additionally,
204 all documents provided to board members shall be available to
205 members of the Legislature in the same manner, and shall be made
206 available to others for a reasonable fee for copying. However,
207 patient confidentiality and provider confidentiality shall be
208 protected by blinding patient names and provider names with
209 numerical or other anonymous identifiers. The board meetings
210 shall be subject to the Open Meetings Act (Section 25-41-1 et
211 seq.). Board meetings conducted in violation of this section
212 shall be deemed unlawful.
213 (5) (a) There is established a Pharmacy and Therapeutics
214 Committee, which shall be appointed by the Governor, or his
215 designee.
216 (b) The committee shall meet at least quarterly, and
217 committee members shall be furnished written notice of the
218 meetings at least ten (10) days before the date of the meeting.
219 (c) The committee meetings shall be open to the public,
220 members of the press, legislators and consumers. Additionally,
221 all documents provided to committee members shall be available to
222 members of the Legislature in the same manner, and shall be made
223 available to others for a reasonable fee for copying. However,
224 patient confidentiality and provider confidentiality shall be
225 protected by blinding patient names and provider names with
226 numerical or other anonymous identifiers. The committee meetings

227 shall be subject to the Open Meetings Act (Section 25-41-1 et
228 seq.). Committee meetings conducted in violation of this section
229 shall be deemed unlawful.

230 (d) After a thirty-day public notice, the executive
231 director, or his or her designee, shall present the division's
232 recommendation regarding prior approval for a therapeutic class of
233 drugs to the committee. However, in circumstances where the
234 division deems it necessary for the health and safety of Medicaid
235 beneficiaries, the division may present to the committee its
236 recommendations regarding a particular drug without a thirty-day
237 public notice. In making that presentation, the division shall
238 state to the committee the circumstances that precipitate the need
239 for the committee to review the status of a particular drug
240 without a thirty-day public notice. The committee may determine
241 whether or not to review the particular drug under the
242 circumstances stated by the division without a thirty-day public
243 notice. If the committee determines to review the status of the
244 particular drug, it shall make its recommendations to the
245 division, after which the division shall file those
246 recommendations for a thirty-day public comment under the
247 provisions of Section 25-43-7(1).

248 (e) Upon reviewing the information and recommendations,
249 the committee shall forward a written recommendation approved by a
250 majority of the committee to the executive director or his or her
251 designee. The decisions of the committee regarding any
252 limitations to be imposed on any drug or its use for a specified
253 indication shall be based on sound clinical evidence found in
254 labeling, drug compendia, and peer reviewed clinical literature
255 pertaining to use of the drug in the relevant population.

256 (f) Upon reviewing and considering all recommendations
257 including recommendation of the committee, comments, and data, the
258 executive director shall make a final determination whether to
259 require prior approval of a therapeutic class of drugs, or modify

260 existing prior approval requirements for a therapeutic class of
261 drugs.
262 (g) At least thirty (30) days before the executive
263 director implements new or amended prior authorization decisions,
264 written notice of the executive director's decision shall be
265 provided to all prescribing Medicaid providers, all Medicaid
266 enrolled pharmacies, and any other party who has requested the
267 notification. However, notice given under Section 25-43-7(1) will
268 substitute for and meet the requirement for notice under this
269 subsection.
270 (h) Members of the committee shall dispose of matters
271 before the committee in an unbiased and professional manner. If a
272 matter being considered by the committee presents a real or
273 apparent conflict of interest for any member of the committee,
274 that member shall disclose the conflict in writing to the
275 committee chair and recuse himself or herself from any discussions
276 and/or actions on the matter.
277 (6) This section shall stand repealed on July 1, 2007.
278 **SECTION 3.** Section 43-13-113, Mississippi Code of 1972, is
279 brought forward as follows:
280 43-13-113. (1) The State Treasurer shall receive on behalf
281 of the state, and execute all instruments incidental thereto,
282 federal and other funds to be used for financing the medical
283 assistance plan or program adopted pursuant to this article, and
284 place all such funds in a special account to the credit of the
285 Governor's Office-Division of Medicaid, which funds shall be
286 expended by the division for the purposes and under the provisions
287 of this article, and shall be paid out by the State Treasurer as
288 funds appropriated to carry out the provisions of this article are
289 paid out by him.
290 The division shall issue all checks or electronic transfers
291 for administrative expenses, and for medical assistance under the
292 provisions of this article. All such checks or electronic

293 transfers shall be drawn upon funds made available to the division
294 by the State Auditor, upon requisition of the director. It is the
295 purpose of this section to provide that the State Auditor shall
296 transfer, in lump sums, amounts to the division for disbursement
297 under the regulations which shall be made by the director with the
298 approval of the Governor; however, the division, or its fiscal
299 agent in behalf of the division, shall be authorized in
300 maintaining separate accounts with a Mississippi bank to handle
301 claim payments, refund recoveries and related Medicaid program
302 financial transactions, to aggressively manage the float in these
303 accounts while awaiting clearance of checks or electronic
304 transfers and/or other disposition so as to accrue maximum
305 interest advantage of the funds in the account, and to retain all
306 earned interest on these funds to be applied to match federal
307 funds for Medicaid program operations.
308 (2) The division is authorized to obtain a line of credit
309 through the State Treasurer from the Working Cash-Stabilization
310 Fund or any other special source funds maintained in the State
311 Treasury in an amount not exceeding One Hundred Fifty Million
312 Dollars ($150,000,000.00) to fund shortfalls which, from time to
313 time, may occur due to decreases in state matching fund cash flow.
314 The length of indebtedness under this provision shall not carry
315 past the end of the quarter following the loan origination. Loan
316 proceeds shall be received by the State Treasurer and shall be
317 placed in a Medicaid designated special fund account. Loan
318 proceeds shall be expended only for health care services provided
319 under the Medicaid program. The division may pledge as security
320 for such interim financing future funds that will be received by
321 the division. Any such loans shall be repaid from the first
322 available funds received by the division in the manner of and
323 subject to the same terms provided in this section.
324 In the event the State Treasurer makes a determination that
325 special source funds are not sufficient to cover a line of credit

326 for the Division of Medicaid, the division is authorized to obtain
327 a line of credit, in an amount not exceeding One Hundred Fifty
328 Million Dollars ($150,000,000.00), from a commercial lender or a
329 consortium of lenders. The length of indebtedness under this
330 provision shall not carry past the end of the quarter following
331 the loan origination. The division shall obtain a minimum of two
332 (2) written quotes that shall be presented to the State Fiscal
333 Officer and State Treasurer, who shall jointly select a lender.
334 Loan proceeds shall be received by the State Treasurer and shall
335 be placed in a Medicaid designated special fund account. Loan
336 proceeds shall be expended only for health care services provided
337 under the Medicaid program. The division may pledge as security
338 for such interim financing future funds that will be received by
339 the division. Any such loans shall be repaid from the first
340 available funds received by the division in the manner of and
341 subject to the same terms provided in this section.

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

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

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

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

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

355 (e) If a claim is neither paid nor denied for valid and
356 proper reasons by the end of the time periods as specified above,
357 the Division of Medicaid's fiscal agent must pay the provider
358 interest on the claim at the rate of one and one-half percent

359 (1-1/2%) per month on the amount of such claim until it is finally
360 settled or adjudicated.
361 (4) The date of receipt is the date the fiscal agent
362 receives the claim as indicated by its date stamp on the claim or,
363 for those claims filed electronically, the date of receipt is the
364 date of transmission.
365 (5) The date of payment is the date of the check or, for
366 those claims paid by electronic funds transfer, the date of the
367 transfer.
368 (6) The above specified time limitations do not apply in the
369 following circumstances:
370 (a) Retroactive adjustments paid to providers
371 reimbursed under a retrospective payment system;
372 (b) If a claim for payment under Medicare has been
373 filed in a timely manner, the fiscal agent may pay a Medicaid
374 claim relating to the same services within six (6) months after
375 it, or the provider, receives notice of the disposition of the
376 Medicare claim;
377 (c) Claims from providers under investigation for fraud
378 or abuse; and
379 (d) The Division of Medicaid and/or its fiscal agent
380 may make payments at any time in accordance with a court order, to
381 carry out hearing decisions or corrective actions taken to resolve
382 a dispute, or to extend the benefits of a hearing decision,
383 corrective action, or court order to others in the same situation
384 as those directly affected by it.
385 (7) Repealed.
386 (8) If sufficient funds are appropriated therefor by the
387 Legislature, the Division of Medicaid may contract with the
388 Mississippi Dental Association, or an approved designee, to
389 develop and operate a Donated Dental Services (DDS) program
390 through which volunteer dentists will treat needy disabled, aged

391 and medically-compromised individuals who are non-Medicaid
392 eligible recipients.
393 **SECTION 4.** Section 43-13-115, Mississippi Code of 1972, is
394 brought forward as follows:
395 43-13-115. Recipients of Medicaid shall be the following
396 persons only:
397 (1) Those who are qualified for public assistance
398 grants under provisions of Title IV-A and E of the federal Social
399 Security Act, as amended, including those statutorily deemed to be
400 IV-A and low-income families and children under Section 1931 of
401 the federal Social Security Act. For the purposes of this
402 paragraph (1) and paragraphs (8), (17) and (18) of this section,
403 any reference to Title IV-A or to Part A of Title IV of the
404 federal Social Security Act, as amended, or the state plan under
405 Title IV-A or Part A of Title IV, shall be considered as a
406 reference to Title IV-A of the federal Social Security Act, as
407 amended, and the state plan under Title IV-A, including the income
408 and resource standards and methodologies under Title IV-A and the
409 state plan, as they existed on July 16, 1996. The Department of
410 Human Services shall determine Medicaid eligibility for children
411 receiving public assistance grants under Title IV-E. The division
412 shall determine eligibility for low-income families under Section
413 1931 of the federal Social Security Act and shall redetermine
414 eligibility for those continuing under Title IV-A grants.
415 (2) Those qualified for Supplemental Security Income
416 (SSI) benefits under Title XVI of the federal Social Security Act,
417 as amended, and those who are deemed SSI eligible as contained in
418 federal statute. The eligibility of individuals covered in this
419 paragraph shall be determined by the Social Security
420 Administration and certified to the Division of Medicaid.
421 (3) Qualified pregnant women who would be eligible for
422 Medicaid as a low-income family member under Section 1931 of the
423 federal Social Security Act if her child were born. The

424 eligibility of the individuals covered under this paragraph shall
425 be determined by the division.
426 (4) [Deleted]
427 (5) A child born on or after October 1, 1984, to a
428 woman eligible for and receiving Medicaid under the state plan on
429 the date of the child's birth shall be deemed to have applied for
430 Medicaid and to have been found eligible for Medicaid under the
431 plan on the date of that birth, and will remain eligible for
432 Medicaid for a period of one (1) year so long as the child is a
433 member of the woman's household and the woman remains eligible for
434 Medicaid or would be eligible for Medicaid if pregnant. The
435 eligibility of individuals covered in this paragraph shall be
436 determined by the Division of Medicaid.
437 (6) Children certified by the State Department of Human
438 Services to the Division of Medicaid of whom the state and county
439 departments of human services have custody and financial
440 responsibility, and children who are in adoptions subsidized in
441 full or part by the Department of Human Services, including
442 special needs children in non-Title IV-E adoption assistance, who
443 are approvable under Title XIX of the Medicaid program. The
444 eligibility of the children covered under this paragraph shall be
445 determined by the State Department of Human Services.
446 (7) Persons certified by the Division of Medicaid who
447 are patients in a medical facility (nursing home, hospital,
448 tuberculosis sanatorium or institution for treatment of mental
449 diseases), and who, except for the fact that they are patients in
450 that medical facility, would qualify for grants under Title IV,
451 Supplementary Security Income (SSI) benefits under Title XVI or
452 state supplements, and those aged, blind and disabled persons who
453 would not be eligible for Supplemental Security Income (SSI)
454 benefits under Title XVI or state supplements if they were not
455 institutionalized in a medical facility but whose income is below

456 the maximum standard set by the Division of Medicaid, which
457 standard shall not exceed that prescribed by federal regulation.
458 (8) Children under eighteen (18) years of age and
459 pregnant women (including those in intact families) who meet the
460 financial standards of the state plan approved under Title IV-A of
461 the federal Social Security Act, as amended. The eligibility of
462 children covered under this paragraph shall be determined by the
463 Division of Medicaid.
464 (9) Individuals who are:
465 (a) Children born after September 30, 1983, who
466 have not attained the age of nineteen (19), with family income
467 that does not exceed one hundred percent (100%) of the nonfarm
468 official poverty level;
469 (b) Pregnant women, infants and children who have
470 not attained the age of six (6), with family income that does not
471 exceed one hundred thirty-three percent (133%) of the federal
472 poverty level; and
473 (c) Pregnant women and infants who have not
474 attained the age of one (1), with family income that does not
475 exceed one hundred eighty-five percent (185%) of the federal
476 poverty level.
477 The eligibility of individuals covered in (a), (b) and (c) of
478 this paragraph shall be determined by the division.
479 (10) Certain disabled children age eighteen (18) or
480 under who are living at home, who would be eligible, if in a
481 medical institution, for SSI or a state supplemental payment under
482 Title XVI of the federal Social Security Act, as amended, and
483 therefore for Medicaid under the plan, and for whom the state has
484 made a determination as required under Section 1902(e)(3)(b) of
485 the federal Social Security Act, as amended. The eligibility of
486 individuals under this paragraph shall be determined by the
487 Division of Medicaid.

488 (11) Until the end of the day on December 31, 2005,
489 individuals who are sixty-five (65) years of age or older or are
490 disabled as determined under Section 1614(a)(3) of the federal
491 Social Security Act, as amended, and whose income does not exceed
492 one hundred thirty-five percent (135%) of the nonfarm official
493 poverty level as defined by the Office of Management and Budget
494 and revised annually, and whose resources do not exceed those
495 established by the Division of Medicaid. The eligibility of
496 individuals covered under this paragraph shall be determined by
497 the Division of Medicaid. After December 31, 2005, only those
498 individuals covered under the 1115(c) Healthier Mississippi waiver
499 will be covered under this category.

500 Any individual who applied for Medicaid during the period
501 from July 1, 2004, through March 31, 2005, who otherwise would
502 have been eligible for coverage under this paragraph (11) if it
503 had been in effect at the time the individual submitted his or her
504 application and is still eligible for coverage under this
505 paragraph (11) on March 31, 2005, shall be eligible for Medicaid
506 coverage under this paragraph (11) from March 31, 2005, through
507 December 31, 2005. The division shall give priority in processing
508 the applications for those individuals to determine their
509 eligibility under this paragraph (11).

510 (12) Individuals who are qualified Medicare
511 beneficiaries (QMB) entitled to Part A Medicare as defined under
512 Section 301, Public Law 100-360, known as the Medicare
513 Catastrophic Coverage Act of 1988, and whose income does not
514 exceed one hundred percent (100%) of the nonfarm official poverty
515 level as defined by the Office of Management and Budget and
516 revised annually.

517 The eligibility of individuals covered under this paragraph
518 shall be determined by the Division of Medicaid, and those
519 individuals determined eligible shall receive Medicare
520 cost-sharing expenses only as more fully defined by the Medicare

521 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
522 1997.
523 (13) (a) Individuals who are entitled to Medicare Part
524 A as defined in Section 4501 of the Omnibus Budget Reconciliation
525 Act of 1990, and whose income does not exceed one hundred twenty
526 percent (120%) of the nonfarm official poverty level as defined by
527 the Office of Management and Budget and revised annually.
528 Eligibility for Medicaid benefits is limited to full payment of
529 Medicare Part B premiums.
530 (b) Individuals entitled to Part A of Medicare,
531 with income above one hundred twenty percent (120%), but less than
532 one hundred thirty-five percent (135%) of the federal poverty
533 level, and not otherwise eligible for Medicaid Eligibility for
534 Medicaid benefits is limited to full payment of Medicare Part B
535 premiums. The number of eligible individuals is limited by the
536 availability of the federal capped allocation at one hundred
537 percent (100%) of federal matching funds, as more fully defined in
538 the Balanced Budget Act of 1997.
539 The eligibility of individuals covered under this paragraph
540 shall be determined by the Division of Medicaid.
541 (14) [Deleted]
542 (15) Disabled workers who are eligible to enroll in
543 Part A Medicare as required by Public Law 101-239, known as the
544 Omnibus Budget Reconciliation Act of 1989, and whose income does
545 not exceed two hundred percent (200%) of the federal poverty level
546 as determined in accordance with the Supplemental Security Income
547 (SSI) program. The eligibility of individuals covered under this
548 paragraph shall be determined by the Division of Medicaid and
549 those individuals shall be entitled to buy-in coverage of Medicare
550 Part A premiums only under the provisions of this paragraph (15).
551 (16) In accordance with the terms and conditions of
552 approved Title XIX waiver from the United States Department of
553 Health and Human Services, persons provided home- and

554 community-based services who are physically disabled and certified
555 by the Division of Medicaid as eligible due to applying the income
556 and deeming requirements as if they were institutionalized.
557 (17) In accordance with the terms of the federal
558 Personal Responsibility and Work Opportunity Reconciliation Act of
559 1996 (Public Law 104-193), persons who become ineligible for
560 assistance under Title IV-A of the federal Social Security Act, as
561 amended, because of increased income from or hours of employment
562 of the caretaker relative or because of the expiration of the
563 applicable earned income disregards, who were eligible for
564 Medicaid for at least three (3) of the six (6) months preceding
565 the month in which the ineligibility begins, shall be eligible for
566 Medicaid for up to twelve (12) months. The eligibility of the
567 individuals covered under this paragraph shall be determined by
568 the division.
569 (18) Persons who become ineligible for assistance under
570 Title IV-A of the federal Social Security Act, as amended, as a
571 result, in whole or in part, of the collection or increased
572 collection of child or spousal support under Title IV-D of the
573 federal Social Security Act, as amended, who were eligible for
574 Medicaid for at least three (3) of the six (6) months immediately
575 preceding the month in which the ineligibility begins, shall be
576 eligible for Medicaid for an additional four (4) months beginning
577 with the month in which the ineligibility begins. The eligibility
578 of the individuals covered under this paragraph shall be
579 determined by the division.
580 (19) Disabled workers, whose incomes are above the
581 Medicaid eligibility limits, but below two hundred fifty percent
582 (250%) of the federal poverty level, shall be allowed to purchase
583 Medicaid coverage on a sliding fee scale developed by the Division
584 of Medicaid.
585 (20) Medicaid eligible children under age eighteen (18)
586 shall remain eligible for Medicaid benefits until the end of a

587 period of twelve (12) months following an eligibility
588 determination, or until such time that the individual exceeds age
589 eighteen (18).
590 (21) Women of childbearing age whose family income does
591 not exceed one hundred eighty-five percent (185%) of the federal
592 poverty level. The eligibility of individuals covered under this
593 paragraph (21) shall be determined by the Division of Medicaid,
594 and those individuals determined eligible shall only receive
595 family planning services covered under Section 43-13-117(13) and
596 not any other services covered under Medicaid. However, any
597 individual eligible under this paragraph (21) who is also eligible
598 under any other provision of this section shall receive the
599 benefits to which he or she is entitled under that other
600 provision, in addition to family planning services covered under
601 Section 43-13-117(13).
602 The Division of Medicaid shall apply to the United States
603 Secretary of Health and Human Services for a federal waiver of the
604 applicable provisions of Title XIX of the federal Social Security
605 Act, as amended, and any other applicable provisions of federal
606 law as necessary to allow for the implementation of this paragraph
607 (21). The provisions of this paragraph (21) shall be implemented
608 from and after the date that the Division of Medicaid receives the
609 federal waiver.
610 (22) Persons who are workers with a potentially severe
611 disability, as determined by the division, shall be allowed to
612 purchase Medicaid coverage. The term "worker with a potentially
613 severe disability" means a person who is at least sixteen (16)
614 years of age but under sixty-five (65) years of age, who has a
615 physical or mental impairment that is reasonably expected to cause
616 the person to become blind or disabled as defined under Section
617 1614(a) of the federal Social Security Act, as amended, if the
618 person does not receive items and services provided under
619 Medicaid.

620 The eligibility of persons under this paragraph (22) shall be
621 conducted as a demonstration project that is consistent with
622 Section 204 of the Ticket to Work and Work Incentives Improvement
623 Act of 1999, Public Law 106-170, for a certain number of persons
624 as specified by the division. The eligibility of individuals
625 covered under this paragraph (22) shall be determined by the
626 Division of Medicaid.

627 (23) Children certified by the Mississippi Department
628 of Human Services for whom the state and county departments of
629 human services have custody and financial responsibility who are
630 in foster care on their eighteenth birthday as reported by the
631 Mississippi Department of Human Services shall be certified
632 Medicaid eligible by the Division of Medicaid until their
633 twenty-first birthday.

634 (24) Individuals who have not attained age sixty-five
635 (65), are not otherwise covered by creditable coverage as defined
636 in the Public Health Services Act, and have been screened for
637 breast and cervical cancer under the Centers for Disease Control
638 and Prevention Breast and Cervical Cancer Early Detection Program
639 established under Title XV of the Public Health Service Act in
640 accordance with the requirements of that act and who need
641 treatment for breast or cervical cancer. Eligibility of
642 individuals under this paragraph (24) shall be determined by the
643 Division of Medicaid.

644 (25) The division shall apply to the Centers for
645 Medicare and Medicaid Services (CMS) for any necessary waivers to
646 provide services to individuals who are sixty-five (65) years of
647 age or older or are disabled as determined under Section
648 1614(a)(3) of the federal Social Security Act, as amended, and
649 whose income does not exceed one hundred thirty-five percent
650 (135%) of the nonfarm official poverty level as defined by the
651 Office of Management and Budget and revised annually, and whose
652 resources do not exceed those established by the Division of

653 Medicaid, and who are not otherwise covered by Medicare. Nothing
654 contained in this paragraph (25) shall entitle an individual to
655 benefits. The eligibility of individuals covered under this
656 paragraph shall be determined by the Division of Medicaid.
657 (26) The division shall apply to the Centers for
658 Medicare and Medicaid Services (CMS) for any necessary waivers to
659 provide services to individuals who are sixty-five (65) years of
660 age or older or are disabled as determined under Section
661 1614(a)(3) of the federal Social Security Act, as amended, who are
662 end stage renal disease patients on dialysis, cancer patients on
663 chemotherapy or organ transplant recipients on anti-rejection
664 drugs, whose income does not exceed one hundred thirty-five
665 percent (135%) of the nonfarm official poverty level as defined by
666 the Office of Management and Budget and revised annually, and
667 whose resources do not exceed those established by the division.
668 Nothing contained in this paragraph (26) shall entitle an
669 individual to benefits. The eligibility of individuals covered
670 under this paragraph shall be determined by the Division of
671 Medicaid.
672 (27) Individuals who are entitled to Medicare Part D
673 and whose income does not exceed one hundred fifty percent (150%)
674 of the nonfarm official poverty level as defined by the Office of
675 Management and Budget and revised annually. Eligibility for
676 payment of the Medicare Part D subsidy under this paragraph shall
677 be determined by the division.
678 The division shall redetermine eligibility for all categories
679 of recipients described in each paragraph of this section not less
680 frequently than required by federal law.
681 **SECTION 5.** Section 43-13-116, Mississippi Code of 1972, is
682 brought forward as follows:
683 43-13-116. (1) It shall be the duty of the Division of
684 Medicaid to fully implement and carry out the administrative

685 functions of determining the eligibility of those persons who
686 qualify for medical assistance under Section 43-13-115.
687 (2) In determining Medicaid eligibility, the Division of
688 Medicaid is authorized to enter into an agreement with the
689 Secretary of the Department of Health and Human Services for the
690 purpose of securing the transfer of eligibility information from
691 the Social Security Administration on those individuals receiving
692 supplemental security income benefits under the federal Social
693 Security Act and any other information necessary in determining
694 Medicaid eligibility. The Division of Medicaid is further
695 empowered to enter into contractual arrangements with its fiscal
696 agent or with the State Department of Human Services in securing
697 electronic data processing support as may be necessary.
698 (3) Administrative hearings shall be available to any
699 applicant who requests it because his or her claim of eligibility
700 for services is denied or is not acted upon with reasonable
701 promptness or by any recipient who requests it because he or she
702 believes the agency has erroneously taken action to deny, reduce,
703 or terminate benefits. The agency need not grant a hearing if the
704 sole issue is a federal or state law requiring an automatic change
705 adversely affecting some or all recipients. Eligibility
706 determinations that are made by other agencies and certified to
707 the Division of Medicaid pursuant to Section 43-13-115 are not
708 subject to the administrative hearing procedures of the Division
709 of Medicaid but are subject to the administrative hearing
710 procedures of the agency that determined eligibility.
711 (a) A request may be made either for a local regional
712 office hearing or a state office hearing when the local regional
713 office has made the initial decision that the claimant seeks to
714 appeal or when the regional office has not acted with reasonable
715 promptness in making a decision on a claim for eligibility or
716 services. The only exception to requesting a local hearing is
717 when the issue under appeal involves either (i) a disability or

718 blindness denial, or termination, or (ii) a level of care denial
719 or termination for a disabled child living at home. An appeal
720 involving disability, blindness or level of care must be handled
721 as a state level hearing. The decision from the local hearing may
722 be appealed to the state office for a state hearing. A decision
723 to deny, reduce or terminate benefits that is initially made at
724 the state office may be appealed by requesting a state hearing.
725 (b) A request for a hearing, either state or local,
726 must be made in writing by the claimant or claimant's legal
727 representative. "Legal representative" includes the claimant's
728 authorized representative, an attorney retained by the claimant or
729 claimant's family to represent the claimant, a paralegal
730 representative with a legal aid services, a parent of a minor
731 child if the claimant is a child, a legal guardian or conservator
732 or an individual with power of attorney for the claimant. The
733 claimant may also be represented by anyone that he or she so
734 designates but must give the designation to the Medicaid regional
735 office or state office in writing, if the person is not the legal
736 representative, legal guardian, or authorized representative.
737 (c) The claimant may make a request for a hearing in
738 person at the regional office but an oral request must be put into
739 written form. Regional office staff will determine from the
740 claimant if a local or state hearing is requested and assist the
741 claimant in completing and signing the appropriate form. Regional
742 office staff may forward a state hearing request to the
743 appropriate division in the state office or the claimant may mail
744 the form to the address listed on the form. The claimant may make
745 a written request for a hearing by letter. A simple statement
746 requesting a hearing that is signed by the claimant or legal
747 representative is sufficient; however, if possible, the claimant
748 should state the reason for the request. The letter may be mailed
749 to the regional office or it may be mailed to the state office. If
750 the letter does not specify the type of hearing desired, local or

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

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

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

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

781 (ii) If a claimant or representative requests a
782 hearing in writing during the advance notice period before
783 benefits are reduced or terminated, benefits must be continued or

784 reinstated to the benefit level in effect before the effective
785 date of the adverse action. Benefits will continue at the
786 original level until the final hearing decision is rendered. Any
787 hearing requested after the advance notice period will not be
788 accepted as a timely request in order for continuation of benefits
789 to apply.

790 (iii) Upon receipt of a written request for a
791 hearing, the request will be acknowledged in writing within twenty
792 (20) days and a hearing scheduled. The claimant or representative
793 will be given at least five (5) days' advance notice of the
794 hearing date. The local and/or state level hearings will be held
795 by telephone unless, at the hearing officer's discretion, it is
796 determined that an in-person hearing is necessary. If a local
797 hearing is requested, the regional office will notify the claimant
798 or representative in writing of the time of the local hearing. If
799 a state hearing is requested, the state office will notify the
800 claimant or representative in writing of the time of the state
801 hearing. If an in-person hearing is necessary, local hearings
802 will be held at the regional office and state hearings will be
803 held at the state office unless other arrangements are
804 necessitated by the claimant's inability to travel.

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

809 (v) A state or local hearing request may be
810 withdrawn at any time before the scheduled hearing, or after the
811 hearing is held but before a decision is rendered. The withdrawal
812 must be in writing and signed by the claimant or representative.
813 A hearing request will be considered abandoned if the claimant or
814 representative fails to appear at a scheduled hearing without good
815 cause. If no one appears for a hearing, the appropriate office
816 will notify the claimant in writing that the hearing is dismissed

817 unless good cause is shown for not attending. The proposed agency
818 action will be taken on the case following failure to appear for a
819 hearing if the action has not already been effected.
820 (vi) The claimant or his representative has the
821 following rights in connection with a local or state hearing:
822 (A) The right to examine at a reasonable time
823 before the date of the hearing and during the hearing the content
824 of the claimant's case record;
825 (B) The right to have legal representation at
826 the hearing and to bring witnesses;
827 (C) The right to produce documentary evidence
828 and establish all facts and circumstances concerning eligibility,
829 services, or benefits;
830 (D) The right to present an argument without
831 undue interference;
832 (E) The right to question or refute any
833 testimony or evidence including an opportunity to confront and
834 cross-examine adverse witnesses.
835 (vii) When a request for a local hearing is
836 received by the regional office or if the regional office is
837 notified by the state office that a local hearing has been
838 requested, the Medicaid specialist supervisor in the regional
839 office will review the case record, reexamine the action taken on
840 the case, and determine if policy and procedures have been
841 followed. If any adjustments or corrections should be made, the
842 Medicaid specialist supervisor will ensure that corrective action
843 is taken. If the request for hearing was timely made such that
844 continuation of benefits applies, the Medicaid specialist
845 supervisor will ensure that benefits continue at the level before
846 the proposed adverse action that is the subject of the appeal.
847 The Medicaid specialist supervisor will also ensure that all
848 needed information, verification, and evidence is in the case
849 record for the hearing.

850 (viii) When a state hearing is requested that
851 appeals the action or inaction of a regional office, the regional
852 office will prepare copies of the case record and forward it to
853 the appropriate division in the state office no later than five
854 (5) days after receipt of the request for a state hearing. The
855 original case record will remain in the regional office. Either
856 the original case record in the regional office or the copy
857 forwarded to the state office will be available for inspection by
858 the claimant or claimant's representative a reasonable time before
859 the date of the hearing.
860 (ix) The Medicaid specialist supervisor will serve
861 as the hearing officer for a local hearing unless the Medicaid
862 specialist supervisor actually participated in the eligibility,
863 benefits, or services decision under appeal, in which case the
864 Medicaid specialist supervisor must appoint a Medicaid specialist
865 in the regional office who did not actually participate in the
866 decision under appeal to serve as hearing officer. The local
867 hearing will be an informal proceeding in which the claimant or
868 representative may present new or additional information, may
869 question the action taken on the client's case, and will hear an
870 explanation from agency staff as to the regulations and
871 requirements that were applied to claimant's case in making the
872 decision.
873 (x) After the hearing, the hearing officer will
874 prepare a written summary of the hearing procedure and file it
875 with the case record. The hearing officer will consider the facts
876 presented at the local hearing in reaching a decision. The
877 claimant will be notified of the local hearing decision on the
878 appropriate form that will state clearly the reason for the
879 decision, the policy that governs the decision, the claimant's
880 right to appeal the decision to the state office, and, if the
881 original adverse action is upheld, the new effective date of the
882 reduction or termination of benefits or services if continuation

883 of benefits applied during the hearing process. The new effective
884 date of the reduction or termination of benefits or services must
885 be at the end of the fifteen-day advance notice period from the
886 mailing date of the notice of hearing decision. The notice to
887 claimant will be made part of the case record.

888 (xi) The claimant has the right to appeal a local
889 hearing decision by requesting a state hearing in writing within
890 fifteen (15) days of the mailing date of the notice of local
891 hearing decision. The state hearing request should be made to the
892 regional office. If benefits have been continued pending the
893 local hearing process, then benefits will continue throughout the
894 fifteen-day advance notice period for an adverse local hearing
895 decision. If a state hearing is timely requested within the
896 fifteen-day period, then benefits will continue pending the state
897 hearing process. State hearings requested after the fifteen-day
898 local hearing advance notice period will not be accepted unless
899 the initial thirty-day period for filing a hearing request has not
900 expired because the local hearing was held early, in which case a
901 state hearing request will be accepted as timely within the number
902 of days remaining of the unexpired initial thirty-day period in
903 addition to the fifteen-day time period. Continuation of benefits
904 during the state hearing process, however, will only apply if the
905 state hearing request is received within the fifteen-day advance
906 notice period.

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

916 office within five (5) days of receipt of the state hearing
917 request.
918 (xiii) Upon receipt of the hearing record, an
919 impartial hearing officer will be assigned to hear the case either
920 by the Executive Director of the Division of Medicaid or his or
921 her designee. Hearing officers will be individuals with
922 appropriate expertise employed by the division and who have not
923 been involved in any way with the action or decision on appeal in
924 the case. The hearing officer will review the case record and if
925 the review shows that an error was made in the action of the
926 agency or in the interpretation of policy, or that a change of
927 policy has been made, the hearing officer will discuss these
928 matters with the appropriate agency personnel and request that an
929 appropriate adjustment be made. Appropriate agency personnel will
930 discuss the matter with the claimant and if the claimant is
931 agreeable to the adjustment of the claim, then agency personnel
932 will request in writing dismissal of the hearing and the reason
933 therefor, to be placed in the case record. If the hearing is to
934 go forward, it shall be scheduled by the hearing officer in the
935 manner set forth in subparagraph (iii) of this paragraph (e).
936 (xiv) In conducting the hearing, the state hearing
937 officer will inform those present of the following:
938 (A) That the hearing will be recorded on tape
939 and that a transcript of the proceedings will be typed for the
940 record;
941 (B) The action taken by the agency which
942 prompted the appeal;
943 (C) An explanation of the claimant's rights
944 during the hearing as outlined in subparagraph (vi) of this
945 paragraph (e);
946 (D) That the purpose of the hearing is for
947 the claimant to express dissatisfaction and present additional
948 information or evidence;

949 (E) That the case record is available for
950 review by the claimant or representative during the hearing;
951 (F) That the final hearing decision will be
952 rendered by the Executive Director of the Division of Medicaid on
953 the basis of facts presented at the hearing and the case record
954 and that the claimant will be notified by letter of the final
955 decision.
956 (xv) During the hearing, the claimant and/or
957 representative will be allowed an opportunity to make a full
958 statement concerning the appeal and will be assisted, if
959 necessary, in disclosing all information on which the claim is
960 based. All persons representing the claimant and those
961 representing the Division of Medicaid will have the opportunity to
962 state all facts pertinent to the appeal. The hearing officer may
963 recess or continue the hearing for a reasonable time should
964 additional information or facts be required or if some change in
965 the claimant's circumstances occurs during the hearing process
966 which impacts the appeal. When all information has been
967 presented, the hearing officer will close the hearing and stop the
968 recorder.
969 (xvi) Immediately following the hearing the
970 hearing tape will be transcribed and a copy of the transcription
971 forwarded to the regional office for filing in the case record.
972 As soon as possible, the hearing officer shall review the evidence
973 and record of the proceedings, testimony, exhibits, and other
974 supporting documents, prepare a written summary of the facts as
975 the hearing officer finds them, and prepare a written
976 recommendation of action to be taken by the agency, citing
977 appropriate policy and regulations that govern the recommendation.
978 The decision cannot be based on any material, oral or written, not
979 available to the claimant before or during the hearing. The
980 hearing officer's recommendation will become part of the case

981 record which will be submitted to the Executive Director of the
982 Division of Medicaid for further review and decision.
983 (xvii) The Executive Director of the Division of
984 Medicaid, upon review of the recommendation, proceedings and the
985 record, may sustain the recommendation of the hearing officer,
986 reject the same, or remand the matter to the hearing officer to
987 take additional testimony and evidence, in which case, the hearing
988 officer thereafter shall submit to the executive director a new
989 recommendation. The executive director shall prepare a written
990 decision summarizing the facts and identifying policies and
991 regulations that support the decision, which shall be mailed to
992 the claimant and the representative, with a copy to the regional
993 office if appropriate, as soon as possible after submission of a
994 recommendation by the hearing officer. The decision notice will
995 specify any action to be taken by the agency, specify any revised
996 eligibility dates or, if continuation of benefits applies, will
997 notify the claimant of the new effective date of reduction or
998 termination of benefits or services, which will be fifteen (15)
999 days from the mailing date of the notice of decision. The
1000 decision rendered by the Executive Director of the Division of
1001 Medicaid is final and binding. The claimant is entitled to seek
1002 judicial review in a court of proper jurisdiction.
1003 (xviii) The Division of Medicaid must take final
1004 administrative action on a hearing, whether state or local, within
1005 ninety (90) days from the date of the initial request for a
1006 hearing.
1007 (xix) A group hearing may be held for a number of
1008 claimants under the following circumstances:
1009 (A) The Division of Medicaid may consolidate
1010 the cases and conduct a single group hearing when the only issue
1011 involved is one (1) of a single law or agency policy;

1012 (B) The claimants may request a group hearing
1013 when there is one (1) issue of agency policy common to all of
1014 them.
1015 In all group hearings, whether initiated by the Division of
1016 Medicaid or by the claimants, the policies governing fair hearings
1017 must be followed. Each claimant in a group hearing must be
1018 permitted to present his or her own case and be represented by his
1019 or her own representative, or to withdraw from the group hearing
1020 and have his or her appeal heard individually. As in individual
1021 hearings, the hearing will be conducted only on the issue being
1022 appealed, and each claimant will be expected to keep individual
1023 testimony within a reasonable time frame as a matter of
1024 consideration to the other claimants involved.
1025 (xx) Any specific matter necessitating an
1026 administrative hearing not otherwise provided under this article
1027 or agency policy shall be afforded under the hearing procedures as
1028 outlined above. If the specific time frames of such a unique
1029 matter relating to requesting, granting, and concluding of the
1030 hearing is contrary to the time frames as set out in the hearing
1031 procedures above, the specific time frames will govern over the
1032 time frames as set out within these procedures.
1033 (4) The Executive Director of the Division of Medicaid, with
1034 the approval of the Governor, shall be authorized to employ
1035 eligibility, technical, clerical and supportive staff as may be
1036 required in carrying out and fully implementing the determination
1037 of Medicaid eligibility, including conducting quality control
1038 reviews and the investigation of the improper receipt of medical
1039 assistance. Staffing needs will be set forth in the annual
1040 appropriation act for the division. Additional office space as
1041 needed in performing eligibility, quality control and
1042 investigative functions shall be obtained by the division.
1043 **SECTION 6.** Section 43-13-117, Mississippi Code of 1972, is
1044 brought forward as follows:

1045 43-13-117. Medicaid as authorized by this article shall
1046 include payment of part or all of the costs, at the discretion of
1047 the division, with approval of the Governor, of the following
1048 types of care and services rendered to eligible applicants who
1049 have been determined to be eligible for that care and services,
1050 within the limits of state appropriations and federal matching
1051 funds:
1052 (1) Inpatient hospital services.
1053 (a) The division shall allow thirty (30) days of
1054 inpatient hospital care annually for all Medicaid recipients.
1055 Precertification of inpatient days must be obtained as required by
1056 the division. The division may allow unlimited days in
1057 disproportionate hospitals as defined by the division for eligible
1058 infants and children under the age of six (6) years if certified
1059 as medically necessary as required by the division.
1060 (b) From and after July 1, 1994, the Executive
1061 Director of the Division of Medicaid shall amend the Mississippi
1062 Title XIX Inpatient Hospital Reimbursement Plan to remove the
1063 occupancy rate penalty from the calculation of the Medicaid
1064 Capital Cost Component utilized to determine total hospital costs
1065 allocated to the Medicaid program.
1066 (c) Hospitals will receive an additional payment
1067 for the implantable programmable baclofen drug pump used to treat
1068 spasticity that is implanted on an inpatient basis. The payment
1069 pursuant to written invoice will be in addition to the facility's
1070 per diem reimbursement and will represent a reduction of costs on
1071 the facility's annual cost report, and shall not exceed Ten
1072 Thousand Dollars ($10,000.00) per year per recipient.
1073 (2) Outpatient hospital services.
1074 (a) Emergency services. The division shall allow
1075 six (6) medically necessary emergency room visits per beneficiary
1076 per fiscal year.

1077 (b) Other outpatient hospital services. The
1078 division shall allow benefits for other medically necessary
1079 outpatient hospital services (such as chemotherapy, radiation,
1080 surgery and therapy). Where the same services are reimbursed as
1081 clinic services, the division may revise the rate or methodology
1082 of outpatient reimbursement to maintain consistency, efficiency,
1083 economy and quality of care.
1084 (3) Laboratory and x-ray services.
1085 (4) Nursing facility services.
1086 (a) The division shall make full payment to
1087 nursing facilities for each day, not exceeding fifty-two (52) days
1088 per year, that a patient is absent from the facility on home
1089 leave. Payment may be made for the following home leave days in
1090 addition to the fifty-two-day limitation: Christmas, the day
1091 before Christmas, the day after Christmas, Thanksgiving, the day
1092 before Thanksgiving and the day after Thanksgiving.
1093 (b) From and after July 1, 1997, the division
1094 shall implement the integrated case-mix payment and quality
1095 monitoring system, which includes the fair rental system for
1096 property costs and in which recapture of depreciation is
1097 eliminated. The division may reduce the payment for hospital
1098 leave and therapeutic home leave days to the lower of the case-mix
1099 category as computed for the resident on leave using the
1100 assessment being utilized for payment at that point in time, or a
1101 case-mix score of 1.000 for nursing facilities, and shall compute
1102 case-mix scores of residents so that only services provided at the
1103 nursing facility are considered in calculating a facility's per
1104 diem.
1105 (c) From and after July 1, 1997, all state-owned
1106 nursing facilities shall be reimbursed on a full reasonable cost
1107 basis.
1108 (d) When a facility of a category that does not
1109 require a certificate of need for construction and that could not

1110 be eligible for Medicaid reimbursement is constructed to nursing
1111 facility specifications for licensure and certification, and the
1112 facility is subsequently converted to a nursing facility under a
1113 certificate of need that authorizes conversion only and the
1114 applicant for the certificate of need was assessed an application
1115 review fee based on capital expenditures incurred in constructing
1116 the facility, the division shall allow reimbursement for capital
1117 expenditures necessary for construction of the facility that were
1118 incurred within the twenty-four (24) consecutive calendar months
1119 immediately preceding the date that the certificate of need
1120 authorizing the conversion was issued, to the same extent that
1121 reimbursement would be allowed for construction of a new nursing
1122 facility under a certificate of need that authorizes that
1123 construction. The reimbursement authorized in this subparagraph
1124 (d) may be made only to facilities the construction of which was
1125 completed after June 30, 1989. Before the division shall be
1126 authorized to make the reimbursement authorized in this
1127 subparagraph (d), the division first must have received approval
1128 from the Centers for Medicare and Medicaid Services (CMS) of the
1129 change in the state Medicaid plan providing for the reimbursement.
1130 (e) The division shall develop and implement, not
1131 later than January 1, 2001, a case-mix payment add-on determined
1132 by time studies and other valid statistical data that will
1133 reimburse a nursing facility for the additional cost of caring for
1134 a resident who has a diagnosis of Alzheimer's or other related
1135 dementia and exhibits symptoms that require special care. Any
1136 such case-mix add-on payment shall be supported by a determination
1137 of additional cost. The division shall also develop and implement
1138 as part of the fair rental reimbursement system for nursing
1139 facility beds, an Alzheimer's resident bed depreciation enhanced
1140 reimbursement system that will provide an incentive to encourage
1141 nursing facilities to convert or construct beds for residents with
1142 Alzheimer's or other related dementia.

1143 (f) The division shall develop and implement an
1144 assessment process for long-term care services. The division may
1145 provide the assessment and related functions directly or through
1146 contract with the area agencies on aging.
1147 The division shall apply for necessary federal waivers to
1148 assure that additional services providing alternatives to nursing
1149 facility care are made available to applicants for nursing
1150 facility care.
1151 (5) Periodic screening and diagnostic services for
1152 individuals under age twenty-one (21) years as are needed to
1153 identify physical and mental defects and to provide health care
1154 treatment and other measures designed to correct or ameliorate
1155 defects and physical and mental illness and conditions discovered
1156 by the screening services, regardless of whether these services
1157 are included in the state plan. The division may include in its
1158 periodic screening and diagnostic program those discretionary
1159 services authorized under the federal regulations adopted to
1160 implement Title XIX of the federal Social Security Act, as
1161 amended. The division, in obtaining physical therapy services,
1162 occupational therapy services, and services for individuals with
1163 speech, hearing and language disorders, may enter into a
1164 cooperative agreement with the State Department of Education for
1165 the provision of those services to handicapped students by public
1166 school districts using state funds that are provided from the
1167 appropriation to the Department of Education to obtain federal
1168 matching funds through the division. The division, in obtaining
1169 medical and psychological evaluations for children in the custody
1170 of the State Department of Human Services may enter into a
1171 cooperative agreement with the State Department of Human Services
1172 for the provision of those services using state funds that are
1173 provided from the appropriation to the Department of Human
1174 Services to obtain federal matching funds through the division.

1175 (6) Physician's services. The division shall allow
1176 twelve (12) physician visits annually. All fees for physicians'
1177 services that are covered only by Medicaid shall be reimbursed at
1178 ninety percent (90%) of the rate established on January 1, 1999,
1179 and as may be adjusted each July thereafter, under Medicare (Title
1180 XVIII of the federal Social Security Act, as amended). The
1181 division may develop and implement a different reimbursement model
1182 or schedule for physician's services provided by physicians based
1183 at an academic health care center and by physicians at rural
1184 health centers that are associated with an academic health care
1185 center.

1186 (7) (a) Home health services for eligible persons, not
1187 to exceed in cost the prevailing cost of nursing facility
1188 services, not to exceed twenty-five (25) visits per year. All
1189 home health visits must be precertified as required by the
1190 division.

1191 (b) Repealed.

1192 (8) Emergency medical transportation services. On
1193 January 1, 1994, emergency medical transportation services shall
1194 be reimbursed at seventy percent (70%) of the rate established
1195 under Medicare (Title XVIII of the federal Social Security Act, as
1196 amended). "Emergency medical transportation services" shall mean,
1197 but shall not be limited to, the following services by a properly
1198 permitted ambulance operated by a properly licensed provider in
1199 accordance with the Emergency Medical Services Act of 1974
1200 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
1201 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
1202 (vi) disposable supplies, (vii) similar services.

1203 (9) (a) Legend and other drugs as may be determined by
1204 the division.

1205 The division shall establish a mandatory preferred drug list.
1206 Drugs not on the mandatory preferred drug list shall be made

1207 available by utilizing prior authorization procedures established
1208 by the division.

1209 The division may seek to establish relationships with other
1210 states in order to lower acquisition costs of prescription drugs
1211 to include single source and innovator multiple source drugs or
1212 generic drugs. In addition, if allowed by federal law or
1213 regulation, the division may seek to establish relationships with
1214 and negotiate with other countries to facilitate the acquisition
1215 of prescription drugs to include single source and innovator
1216 multiple source drugs or generic drugs, if that will lower the
1217 acquisition costs of those prescription drugs.

1218 The division shall allow for a combination of prescriptions
1219 for single source and innovator multiple source drugs and generic
1220 drugs to meet the needs of the beneficiaries, not to exceed five
1221 (5) prescriptions per month for each noninstitutionalized Medicaid
1222 beneficiary, with not more than two (2) of those prescriptions
1223 being for single source or innovator multiple source drugs.

1224 The executive director may approve specific maintenance drugs
1225 for beneficiaries with certain medical conditions, which may be
1226 prescribed and dispensed in three-month supply increments. The
1227 executive director may allow a state agency or agencies to be the
1228 sole source purchaser and distributor of hemophilia factor
1229 medications, HIV/AIDS medications and other medications as
1230 determined by the executive director as allowed by federal
1231 regulations.

1232 Drugs prescribed for a resident of a psychiatric residential
1233 treatment facility must be provided in true unit doses when
1234 available. The division may require that drugs not covered by
1235 Medicare Part D for a resident of a long-term care facility be
1236 provided in true unit doses when available. Those drugs that were
1237 originally billed to the division but are not used by a resident
1238 in any of those facilities shall be returned to the billing
1239 pharmacy for credit to the division, in accordance with the

1240 guidelines of the State Board of Pharmacy and any requirements of
1241 federal law and regulation. Drugs shall be dispensed to a
1242 recipient and only one (1) dispensing fee per month may be
1243 charged. The division shall develop a methodology for reimbursing
1244 for restocked drugs, which shall include a restock fee as
1245 determined by the division not exceeding Seven Dollars and
1246 Eighty-two Cents ($7.82).
1247 The voluntary preferred drug list shall be expanded to
1248 function in the interim in order to have a manageable prior
1249 authorization system, thereby minimizing disruption of service to
1250 beneficiaries.
1251 Except for those specific maintenance drugs approved by the
1252 executive director, the division shall not reimburse for any
1253 portion of a prescription that exceeds a thirty-one-day supply of
1254 the drug based on the daily dosage.
1255 The division shall develop and implement a program of payment
1256 for additional pharmacist services, with payment to be based on
1257 demonstrated savings, but in no case shall the total payment
1258 exceed twice the amount of the dispensing fee.
1259 All claims for drugs for dually eligible Medicare/Medicaid
1260 beneficiaries that are paid for by Medicare must be submitted to
1261 Medicare for payment before they may be processed by the
1262 division's on-line payment system.
1263 The division shall develop a pharmacy policy in which drugs
1264 in tamper-resistant packaging that are prescribed for a resident
1265 of a nursing facility but are not dispensed to the resident shall
1266 be returned to the pharmacy and not billed to Medicaid, in
1267 accordance with guidelines of the State Board of Pharmacy.
1268 The division shall develop and implement a method or methods
1269 by which the division will provide on a regular basis to Medicaid
1270 providers who are authorized to prescribe drugs, information about
1271 the costs to the Medicaid program of single source drugs and
1272 innovator multiple source drugs, and information about other drugs

1273 that may be prescribed as alternatives to those single source
1274 drugs and innovator multiple source drugs and the costs to the
1275 Medicaid program of those alternative drugs.

1276 Notwithstanding any law or regulation, information obtained
1277 or maintained by the division regarding the prescription drug
1278 program, including trade secrets and manufacturer or labeler
1279 pricing, is confidential and not subject to disclosure except to
1280 other state agencies.

1281 (b) Payment by the division for covered
1282 multisource drugs shall be limited to the lower of the upper
1283 limits established and published by the Centers for Medicare and
1284 Medicaid Services (CMS) plus a dispensing fee, or the estimated
1285 acquisition cost (EAC) as determined by the division, plus a
1286 dispensing fee, or the providers' usual and customary charge to
1287 the general public.

1288 Payment for other covered drugs, other than multisource drugs
1289 with CMS upper limits, shall not exceed the lower of the estimated
1290 acquisition cost as determined by the division, plus a dispensing
1291 fee or the providers' usual and customary charge to the general
1292 public.

1293 Payment for nonlegend or over-the-counter drugs covered by
1294 the division shall be reimbursed at the lower of the division's
1295 estimated shelf price or the providers' usual and customary charge
1296 to the general public.

1297 The dispensing fee for each new or refill prescription,
1298 including nonlegend or over-the-counter drugs covered by the
1299 division, shall be not less than Three Dollars and Ninety-one
1300 Cents ($3.91), as determined by the division.

1301 The division shall not reimburse for single source or
1302 innovator multiple source drugs if there are equally effective
1303 generic equivalents available and if the generic equivalents are
1304 the least expensive.

1305 It is the intent of the Legislature that the pharmacists
1306 providers be reimbursed for the reasonable costs of filling and
1307 dispensing prescriptions for Medicaid beneficiaries.
1308 (10) Dental care that is an adjunct to treatment of an
1309 acute medical or surgical condition; services of oral surgeons and
1310 dentists in connection with surgery related to the jaw or any
1311 structure contiguous to the jaw or the reduction of any fracture
1312 of the jaw or any facial bone; and emergency dental extractions
1313 and treatment related thereto. On July 1, 1999, all fees for
1314 dental care and surgery under authority of this paragraph (10)
1315 shall be increased to one hundred sixty percent (160%) of the
1316 amount of the reimbursement rate that was in effect on June 30,
1317 1999. It is the intent of the Legislature to encourage more
1318 dentists to participate in the Medicaid program.
1319 (11) Eyeglasses for all Medicaid beneficiaries who have
1320 (a) had surgery on the eyeball or ocular muscle that results in a
1321 vision change for which eyeglasses or a change in eyeglasses is
1322 medically indicated within six (6) months of the surgery and is in
1323 accordance with policies established by the division, or (b) one
1324 (1) pair every five (5) years and in accordance with policies
1325 established by the division. In either instance, the eyeglasses
1326 must be prescribed by a physician skilled in diseases of the eye
1327 or an optometrist, whichever the beneficiary may select.
1328 (12) Intermediate care facility services.
1329 (a) The division shall make full payment to all
1330 intermediate care facilities for the mentally retarded for each
1331 day, not exceeding eighty-four (84) days per year, that a patient
1332 is absent from the facility on home leave. Payment may be made
1333 for the following home leave days in addition to the
1334 eighty-four-day limitation: Christmas, the day before Christmas,
1335 the day after Christmas, Thanksgiving, the day before Thanksgiving
1336 and the day after Thanksgiving.

1337 (b) All state-owned intermediate care facilities
1338 for the mentally retarded shall be reimbursed on a full reasonable
1339 cost basis.
1340 (13) Family planning services, including drugs,
1341 supplies and devices, when those services are under the
1342 supervision of a physician or nurse practitioner.
1343 (14) Clinic services. Such diagnostic, preventive,
1344 therapeutic, rehabilitative or palliative services furnished to an
1345 outpatient by or under the supervision of a physician or dentist
1346 in a facility that is not a part of a hospital but that is
1347 organized and operated to provide medical care to outpatients.
1348 Clinic services shall include any services reimbursed as
1349 outpatient hospital services that may be rendered in such a
1350 facility, including those that become so after July 1, 1991. On
1351 July 1, 1999, all fees for physicians' services reimbursed under
1352 authority of this paragraph (14) shall be reimbursed at ninety
1353 percent (90%) of the rate established on January 1, 1999, and as
1354 may be adjusted each July thereafter, under Medicare (Title XVIII
1355 of the federal Social Security Act, as amended). The division may
1356 develop and implement a different reimbursement model or schedule
1357 for physician's services provided by physicians based at an
1358 academic health care center and by physicians at rural health
1359 centers that are associated with an academic health care center.
1360 On July 1, 1999, all fees for dentists' services reimbursed under
1361 authority of this paragraph (14) shall be increased to one hundred
1362 sixty percent (160%) of the amount of the reimbursement rate that
1363 was in effect on June 30, 1999.
1364 (15) Home- and community-based services for the elderly
1365 and disabled, as provided under Title XIX of the federal Social
1366 Security Act, as amended, under waivers, subject to the
1367 availability of funds specifically appropriated for that purpose
1368 by the Legislature.

1369 (16) Mental health services. Approved therapeutic and
1370 case management services (a) provided by an approved regional
1371 mental health/retardation center established under Sections
1372 41-19-31 through 41-19-39, or by another community mental health
1373 service provider meeting the requirements of the Department of
1374 Mental Health to be an approved mental health/retardation center
1375 if determined necessary by the Department of Mental Health, using
1376 state funds that are provided from the appropriation to the State
1377 Department of Mental Health and/or funds transferred to the
1378 department by a political subdivision or instrumentality of the
1379 state and used to match federal funds under a cooperative
1380 agreement between the division and the department, or (b) provided
1381 by a facility that is certified by the State Department of Mental
1382 Health to provide therapeutic and case management services, to be
1383 reimbursed on a fee for service basis, or (c) provided in the
1384 community by a facility or program operated by the Department of
1385 Mental Health. Any such services provided by a facility described
1386 in subparagraph (b) must have the prior approval of the division
1387 to be reimbursable under this section. After June 30, 1997,
1388 mental health services provided by regional mental
1389 health/retardation centers established under Sections 41-19-31
1390 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
1391 and/or their subsidiaries and divisions, or by psychiatric
1392 residential treatment facilities as defined in Section 43-11-1, or
1393 by another community mental health service provider meeting the
1394 requirements of the Department of Mental Health to be an approved
1395 mental health/retardation center if determined necessary by the
1396 Department of Mental Health, shall not be included in or provided
1397 under any capitated managed care pilot program provided for under
1398 paragraph (24) of this section.
1399 (17) Durable medical equipment services and medical
1400 supplies. Precertification of durable medical equipment and
1401 medical supplies must be obtained as required by the division.

1402 The Division of Medicaid may require durable medical equipment
1403 providers to obtain a surety bond in the amount and to the
1404 specifications as established by the Balanced Budget Act of 1997.
1405 (18) (a) Notwithstanding any other provision of this
1406 section to the contrary, the division shall make additional
1407 reimbursement to hospitals that serve a disproportionate share of
1408 low-income patients and that meet the federal requirements for
1409 those payments as provided in Section 1923 of the federal Social
1410 Security Act and any applicable regulations. However, from and
1411 after January 1, 1999, no public hospital shall participate in the
1412 Medicaid disproportionate share program unless the public hospital
1413 participates in an intergovernmental transfer program as provided
1414 in Section 1903 of the federal Social Security Act and any
1415 applicable regulations.
1416 (b) The division shall establish a Medicare Upper
1417 Payment Limits Program, as defined in Section 1902(a)(30) of the
1418 federal Social Security Act and any applicable federal
1419 regulations, for hospitals, and may establish a Medicare Upper
1420 Payments Limits Program for nursing facilities. The division
1421 shall assess each hospital and, if the program is established for
1422 nursing facilities, shall assess each nursing facility, based on
1423 Medicaid utilization or other appropriate method consistent with
1424 federal regulations. The assessment will remain in effect as long
1425 as the state participates in the Medicare Upper Payment Limits
1426 Program. The division shall make additional reimbursement to
1427 hospitals and, if the program is established for nursing
1428 facilities, shall make additional reimbursement to nursing
1429 facilities, for the Medicare Upper Payment Limits, as defined in
1430 Section 1902(a)(30) of the federal Social Security Act and any
1431 applicable federal regulations.
1432 (19) (a) Perinatal risk management services. The
1433 division shall promulgate regulations to be effective from and
1434 after October 1, 1988, to establish a comprehensive perinatal

1435 system for risk assessment of all pregnant and infant Medicaid
1436 recipients and for management, education and follow-up for those
1437 who are determined to be at risk. Services to be performed
1438 include case management, nutrition assessment/counseling,
1439 psychosocial assessment/counseling and health education.
1440 (b) Early intervention system services. The
1441 division shall cooperate with the State Department of Health,
1442 acting as lead agency, in the development and implementation of a
1443 statewide system of delivery of early intervention services, under
1444 Part C of the Individuals with Disabilities Education Act (IDEA).
1445 The State Department of Health shall certify annually in writing
1446 to the executive director of the division the dollar amount of
1447 state early intervention funds available that will be utilized as
1448 a certified match for Medicaid matching funds. Those funds then
1449 shall be used to provide expanded targeted case management
1450 services for Medicaid eligible children with special needs who are
1451 eligible for the state's early intervention system.
1452 Qualifications for persons providing service coordination shall be
1453 determined by the State Department of Health and the Division of
1454 Medicaid.
1455 (20) Home- and community-based services for physically
1456 disabled approved services as allowed by a waiver from the United
1457 States Department of Health and Human Services for home- and
1458 community-based services for physically disabled people using
1459 state funds that are provided from the appropriation to the State
1460 Department of Rehabilitation Services and used to match federal
1461 funds under a cooperative agreement between the division and the
1462 department, provided that funds for these services are
1463 specifically appropriated to the Department of Rehabilitation
1464 Services.
1465 (21) Nurse practitioner services. Services furnished
1466 by a registered nurse who is licensed and certified by the
1467 Mississippi Board of Nursing as a nurse practitioner, including,

1468 but not limited to, nurse anesthetists, nurse midwives, family
1469 nurse practitioners, family planning nurse practitioners,
1470 pediatric nurse practitioners, obstetrics-gynecology nurse
1471 practitioners and neonatal nurse practitioners, under regulations
1472 adopted by the division. Reimbursement for those services shall
1473 not exceed ninety percent (90%) of the reimbursement rate for
1474 comparable services rendered by a physician.
1475 (22) Ambulatory services delivered in federally
1476 qualified health centers, rural health centers and clinics of the
1477 local health departments of the State Department of Health for
1478 individuals eligible for Medicaid under this article based on
1479 reasonable costs as determined by the division.
1480 (23) Inpatient psychiatric services. Inpatient
1481 psychiatric services to be determined by the division for
1482 recipients under age twenty-one (21) that are provided under the
1483 direction of a physician in an inpatient program in a licensed
1484 acute care psychiatric facility or in a licensed psychiatric
1485 residential treatment facility, before the recipient reaches age
1486 twenty-one (21) or, if the recipient was receiving the services
1487 immediately before he or she reached age twenty-one (21), before
1488 the earlier of the date he or she no longer requires the services
1489 or the date he or she reaches age twenty-two (22), as provided by
1490 federal regulations. Precertification of inpatient days and
1491 residential treatment days must be obtained as required by the
1492 division.
1493 (24) [Deleted]
1494 (25) [Deleted]
1495 (26) Hospice care. As used in this paragraph, the term
1496 "hospice care" means a coordinated program of active professional
1497 medical attention within the home and outpatient and inpatient
1498 care that treats the terminally ill patient and family as a unit,
1499 employing a medically directed interdisciplinary team. The
1500 program provides relief of severe pain or other physical symptoms

1501 and supportive care to meet the special needs arising out of
1502 physical, psychological, spiritual, social and economic stresses
1503 that are experienced during the final stages of illness and during
1504 dying and bereavement and meets the Medicare requirements for
1505 participation as a hospice as provided in federal regulations.

1506 (27) Group health plan premiums and cost sharing if it
1507 is cost effective as defined by the United States Secretary of
1508 Health and Human Services.

1509 (28) Other health insurance premiums that are cost
1510 effective as defined by the United States Secretary of Health and
1511 Human Services. Medicare eligible must have Medicare Part B
1512 before other insurance premiums can be paid.

1513 (29) The Division of Medicaid may apply for a waiver
1514 from the United States Department of Health and Human Services for
1515 home- and community-based services for developmentally disabled
1516 people using state funds that are provided from the appropriation
1517 to the State Department of Mental Health and/or funds transferred
1518 to the department by a political subdivision or instrumentality of
1519 the state and used to match federal funds under a cooperative
1520 agreement between the division and the department, provided that
1521 funds for these services are specifically appropriated to the
1522 Department of Mental Health and/or transferred to the department
1523 by a political subdivision or instrumentality of the state.

1524 (30) Pediatric skilled nursing services for eligible
1525 persons under twenty-one (21) years of age.

1526 (31) Targeted case management services for children
1527 with special needs, under waivers from the United States
1528 Department of Health and Human Services, using state funds that
1529 are provided from the appropriation to the Mississippi Department
1530 of Human Services and used to match federal funds under a
1531 cooperative agreement between the division and the department.

1532 (32) Care and services provided in Christian Science
1533 Sanatoria listed and certified by the Commission for Accreditation

1534 of Christian Science Nursing Organizations/Facilities, Inc.,
1535 rendered in connection with treatment by prayer or spiritual means
1536 to the extent that those services are subject to reimbursement
1537 under Section 1903 of the federal Social Security Act.

1538 (33) Podiatrist services.

1539 (34) Assisted living services as provided through home-
1540 and community-based services under Title XIX of the federal Social
1541 Security Act, as amended, subject to the availability of funds
1542 specifically appropriated for that purpose by the Legislature.

1543 (35) Services and activities authorized in Sections
1544 43-27-101 and 43-27-103, using state funds that are provided from
1545 the appropriation to the State Department of Human Services and
1546 used to match federal funds under a cooperative agreement between
1547 the division and the department.

1548 (36) Nonemergency transportation services for
1549 Medicaid-eligible persons, to be provided by the Division of
1550 Medicaid. The division may contract with additional entities to
1551 administer nonemergency transportation services as it deems
1552 necessary. All providers shall have a valid driver's license,
1553 vehicle inspection sticker, valid vehicle license tags and a
1554 standard liability insurance policy covering the vehicle. The
1555 division may pay providers a flat fee based on mileage tiers, or
1556 in the alternative, may reimburse on actual miles traveled. The
1557 division may apply to the Center for Medicare and Medicaid
1558 Services (CMS) for a waiver to draw federal matching funds for
1559 nonemergency transportation services as a covered service instead
1560 of an administrative cost.

1561 (37) [Deleted]

1562 (38) Chiropractic services. A chiropractor's manual
1563 manipulation of the spine to correct a subluxation, if x-ray
1564 demonstrates that a subluxation exists and if the subluxation has
1565 resulted in a neuromusculoskeletal condition for which
1566 manipulation is appropriate treatment, and related spinal x-rays

1567 performed to document these conditions. Reimbursement for
1568 chiropractic services shall not exceed Seven Hundred Dollars
1569 ($700.00) per year per beneficiary.
1570 (39) Dually eligible Medicare/Medicaid beneficiaries.
1571 The division shall pay the Medicare deductible and coinsurance
1572 amounts for services available under Medicare, as determined by
1573 the division.
1574 (40) [Deleted]
1575 (41) Services provided by the State Department of
1576 Rehabilitation Services for the care and rehabilitation of persons
1577 with spinal cord injuries or traumatic brain injuries, as allowed
1578 under waivers from the United States Department of Health and
1579 Human Services, using up to seventy-five percent (75%) of the
1580 funds that are appropriated to the Department of Rehabilitation
1581 Services from the Spinal Cord and Head Injury Trust Fund
1582 established under Section 37-33-261 and used to match federal
1583 funds under a cooperative agreement between the division and the
1584 department.
1585 (42) Notwithstanding any other provision in this
1586 article to the contrary, the division may develop a population
1587 health management program for women and children health services
1588 through the age of one (1) year. This program is primarily for
1589 obstetrical care associated with low birth weight and pre-term
1590 babies. The division may apply to the federal Centers for
1591 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
1592 any other waivers that may enhance the program. In order to
1593 effect cost savings, the division may develop a revised payment
1594 methodology that may include at-risk capitated payments, and may
1595 require member participation in accordance with the terms and
1596 conditions of an approved federal waiver.
1597 (43) The division shall provide reimbursement,
1598 according to a payment schedule developed by the division, for
1599 smoking cessation medications for pregnant women during their

1600 pregnancy and other Medicaid-eligible women who are of
1601 child-bearing age.
1602 (44) Nursing facility services for the severely
1603 disabled.
1604 (a) Severe disabilities include, but are not
1605 limited to, spinal cord injuries, closed head injuries and
1606 ventilator dependent patients.
1607 (b) Those services must be provided in a long-term
1608 care nursing facility dedicated to the care and treatment of
1609 persons with severe disabilities, and shall be reimbursed as a
1610 separate category of nursing facilities.
1611 (45) Physician assistant services. Services furnished
1612 by a physician assistant who is licensed by the State Board of
1613 Medical Licensure and is practicing with physician supervision
1614 under regulations adopted by the board, under regulations adopted
1615 by the division. Reimbursement for those services shall not
1616 exceed ninety percent (90%) of the reimbursement rate for
1617 comparable services rendered by a physician.
1618 (46) The division shall make application to the federal
1619 Centers for Medicare and Medicaid Services (CMS) for a waiver to
1620 develop and provide services for children with serious emotional
1621 disturbances as defined in Section 43-14-1(1), which may include
1622 home- and community-based services, case management services or
1623 managed care services through mental health providers certified by
1624 the Department of Mental Health. The division may implement and
1625 provide services under this waivered program only if funds for
1626 these services are specifically appropriated for this purpose by
1627 the Legislature, or if funds are voluntarily provided by affected
1628 agencies.
1629 (47) (a) Notwithstanding any other provision in this
1630 article to the contrary, the division, in conjunction with the
1631 State Department of Health, may develop and implement disease
1632 management programs for individuals with high-cost chronic

1633 diseases and conditions, including the use of grants, waivers,
1634 demonstrations or other projects as necessary.

1635 (b) Participation in any disease management
1636 program implemented under this paragraph (47) is optional with the
1637 individual. An individual must affirmatively elect to participate
1638 in the disease management program in order to participate.

1639 (c) An individual who participates in the disease
1640 management program has the option of participating in the
1641 prescription drug home delivery component of the program at any
1642 time while participating in the program. An individual must
1643 affirmatively elect to participate in the prescription drug home
1644 delivery component in order to participate.

1645 (d) An individual who participates in the disease
1646 management program may elect to discontinue participation in the
1647 program at any time. An individual who participates in the
1648 prescription drug home delivery component may elect to discontinue
1649 participation in the prescription drug home delivery component at
1650 any time.

1651 (e) The division shall send written notice to all
1652 individuals who participate in the disease management program
1653 informing them that they may continue using their local pharmacy
1654 or any other pharmacy of their choice to obtain their prescription
1655 drugs while participating in the program.

1656 (f) Prescription drugs that are provided to
1657 individuals under the prescription drug home delivery component
1658 shall be limited only to those drugs that are used for the
1659 treatment, management or care of asthma, diabetes or hypertension.

1660 (48) Pediatric long-term acute care hospital services.

1661 (a) Pediatric long-term acute care hospital
1662 services means services provided to eligible persons under
1663 twenty-one (21) years of age by a freestanding Medicare-certified
1664 hospital that has an average length of inpatient stay greater than
1665 twenty-five (25) days and that is primarily engaged in providing

1666 chronic or long-term medical care to persons under twenty-one (21)
1667 years of age.

1668 (b) The services under this paragraph (48) shall
1669 be reimbursed as a separate category of hospital services.

1670 (49) The division shall establish co-payments and/or
1671 coinsurance for all Medicaid services for which co-payments and/or
1672 coinsurance are allowable under federal law or regulation, and
1673 shall set the amount of the co-payment and/or coinsurance for each
1674 of those services at the maximum amount allowable under federal
1675 law or regulation.

1676 (50) Services provided by the State Department of
1677 Rehabilitation Services for the care and rehabilitation of persons
1678 who are deaf and blind, as allowed under waivers from the United
1679 States Department of Health and Human Services to provide home-
1680 and community-based services using state funds that are provided
1681 from the appropriation to the State Department of Rehabilitation
1682 Services or if funds are voluntarily provided by another agency.

1683 (51) Upon determination of Medicaid eligibility and in
1684 association with annual redetermination of Medicaid eligibility,
1685 beneficiaries shall be encouraged to undertake a physical
1686 examination that will establish a base-line level of health and
1687 identification of a usual and customary source of care (a medical
1688 home) to aid utilization of disease management tools. This
1689 physical examination and utilization of these disease management
1690 tools shall be consistent with current United States Preventive
1691 Services Task Force or other recognized authority recommendations.

1692 For persons who are determined ineligible for Medicaid, the
1693 division will provide information and direction for accessing
1694 medical care and services in the area of their residence.

1695 (52) Notwithstanding any provisions of this article,
1696 the division may pay enhanced reimbursement fees related to trauma
1697 care, as determined by the division in conjunction with the State
1698 Department of Health, using funds appropriated to the State

1699 Department of Health for trauma care and services and used to
1700 match federal funds under a cooperative agreement between the
1701 division and the State Department of Health. The division, in
1702 conjunction with the State Department of Health, may use grants,
1703 waivers, demonstrations, or other projects as necessary in the
1704 development and implementation of this reimbursement program.
1705 (53) Targeted case management services for high-cost
1706 beneficiaries shall be developed by the division for all services
1707 under this section.
1708 Notwithstanding any other provision of this article to the
1709 contrary, the division shall reduce the rate of reimbursement to
1710 providers for any service provided under this section by five
1711 percent (5%) of the allowed amount for that service. However, the
1712 reduction in the reimbursement rates required by this paragraph
1713 shall not apply to inpatient hospital services, nursing facility
1714 services, intermediate care facility services, psychiatric
1715 residential treatment facility services, pharmacy services
1716 provided under paragraph (9) of this section, or any service
1717 provided by the University of Mississippi Medical Center or a
1718 state agency, a state facility or a public agency that either
1719 provides its own state match through intergovernmental transfer or
1720 certification of funds to the division, or a service for which the
1721 federal government sets the reimbursement methodology and rate.
1722 In addition, the reduction in the reimbursement rates required by
1723 this paragraph shall not apply to case management services and
1724 home-delivered meals provided under the home- and community-based
1725 services program for the elderly and disabled by a planning and
1726 development district (PDD). Planning and development districts
1727 participating in the home- and community-based services program
1728 for the elderly and disabled as case management providers shall be
1729 reimbursed for case management services at the maximum rate
1730 approved by the Centers for Medicare and Medicaid Services (CMS).

1731 The division may pay to those providers who participate in
1732 and accept patient referrals from the division's emergency room
1733 redirection program a percentage, as determined by the division,
1734 of savings achieved according to the performance measures and
1735 reduction of costs required of that program. Federally qualified
1736 health centers may participate in the emergency room redirection
1737 program, and the division may pay those centers a percentage of
1738 any savings to the Medicaid program achieved by the centers'
1739 accepting patient referrals through the program, as provided in
1740 this paragraph.

1741 Notwithstanding any provision of this article, except as
1742 authorized in the following paragraph and in Section 43-13-139,
1743 neither (a) the limitations on quantity or frequency of use of or
1744 the fees or charges for any of the care or services available to
1745 recipients under this section, nor (b) the payments or rates of
1746 reimbursement to providers rendering care or services authorized
1747 under this section to recipients, may be increased, decreased or
1748 otherwise changed from the levels in effect on July 1, 1999,
1749 unless they are authorized by an amendment to this section by the
1750 Legislature. However, the restriction in this paragraph shall not
1751 prevent the division from changing the payments or rates of
1752 reimbursement to providers without an amendment to this section
1753 whenever those changes are required by federal law or regulation,
1754 or whenever those changes are necessary to correct administrative
1755 errors or omissions in calculating those payments or rates of
1756 reimbursement.

1757 Notwithstanding any provision of this article, no new groups
1758 or categories of recipients and new types of care and services may
1759 be added without enabling legislation from the Mississippi
1760 Legislature, except that the division may authorize those changes
1761 without enabling legislation when the addition of recipients or
1762 services is ordered by a court of proper authority.

1763 The executive director shall keep the Governor advised on a
1764 timely basis of the funds available for expenditure and the
1765 projected expenditures. If current or projected expenditures of
1766 the division are reasonably anticipated to exceed the amount of
1767 funds appropriated to the division for any fiscal year, the
1768 Governor, after consultation with the executive director, shall
1769 discontinue any or all of the payment of the types of care and
1770 services as provided in this section that are deemed to be
1771 optional services under Title XIX of the federal Social Security
1772 Act, as amended, and when necessary, shall institute any other
1773 cost containment measures on any program or programs authorized
1774 under the article to the extent allowed under the federal law
1775 governing that program or programs. However, the Governor shall
1776 not be authorized to discontinue or eliminate any service under
1777 this section that is mandatory under federal law, or to
1778 discontinue or eliminate, or adjust income limits or resource
1779 limits for, any eligibility category or group under Section
1780 43-13-115. It is the intent of the Legislature that the
1781 expenditures of the division during any fiscal year shall not
1782 exceed the amounts appropriated to the division for that fiscal
1783 year.
1784 Notwithstanding any other provision of this article, it shall
1785 be the duty of each nursing facility, intermediate care facility
1786 for the mentally retarded, psychiatric residential treatment
1787 facility, and nursing facility for the severely disabled that is
1788 participating in the Medicaid program to keep and maintain books,
1789 documents and other records as prescribed by the Division of
1790 Medicaid in substantiation of its cost reports for a period of
1791 three (3) years after the date of submission to the Division of
1792 Medicaid of an original cost report, or three (3) years after the
1793 date of submission to the Division of Medicaid of an amended cost
1794 report.

1795 **SECTION 7.** Section 43-13-121, Mississippi Code of 1972, is
1796 brought forward as follows:
1797 43-13-121. (1) The division shall administer the Medicaid
1798 program under the provisions of this article, and may do the
1799 following:
1800 (a) Adopt and promulgate reasonable rules, regulations
1801 and standards, with approval of the Governor, and in accordance
1802 with the Administrative Procedures Law, Section 25-43-1 et seq.:
1803 (i) Establishing methods and procedures as may be
1804 necessary for the proper and efficient administration of this
1805 article;
1806 (ii) Providing Medicaid to all qualified
1807 recipients under the provisions of this article as the division
1808 may determine and within the limits of appropriated funds;
1809 (iii) Establishing reasonable fees, charges and
1810 rates for medical services and drugs; in doing so, the division
1811 shall fix all of those fees, charges and rates at the minimum
1812 levels absolutely necessary to provide the medical assistance
1813 authorized by this article, and shall not change any of those
1814 fees, charges or rates except as may be authorized in Section
1815 43-13-117;
1816 (iv) Providing for fair and impartial hearings;
1817 (v) Providing safeguards for preserving the
1818 confidentiality of records; and
1819 (vi) For detecting and processing fraudulent
1820 practices and abuses of the program;
1821 (b) Receive and expend state, federal and other funds
1822 in accordance with court judgments or settlements and agreements
1823 between the State of Mississippi and the federal government, the
1824 rules and regulations promulgated by the division, with the
1825 approval of the Governor, and within the limitations and
1826 restrictions of this article and within the limits of funds
1827 available for that purpose;

1828 (c) Subject to the limits imposed by this article, to
1829 submit a Medicaid plan to the United States Department of Health
1830 and Human Services for approval under the provisions of the
1831 federal Social Security Act, to act for the state in making
1832 negotiations relative to the submission and approval of that plan,
1833 to make such arrangements, not inconsistent with the law, as may
1834 be required by or under federal law to obtain and retain that
1835 approval and to secure for the state the benefits of the
1836 provisions of that law.

1837 No agreements, specifically including the general plan for
1838 the operation of the Medicaid program in this state, shall be made
1839 by and between the division and the United States Department of
1840 Health and Human Services unless the Attorney General of the State
1841 of Mississippi has reviewed the agreements, specifically including
1842 the operational plan, and has certified in writing to the Governor
1843 and to the executive director of the division that the agreements,
1844 including the plan of operation, have been drawn strictly in
1845 accordance with the terms and requirements of this article;

1846 (d) In accordance with the purposes and intent of this
1847 article and in compliance with its provisions, provide for aged
1848 persons otherwise eligible for the benefits provided under Title
1849 XVIII of the federal Social Security Act by expenditure of funds
1850 available for those purposes;

1851 (e) To make reports to the United States Department of
1852 Health and Human Services as from time to time may be required by
1853 that federal department and to the Mississippi Legislature as
1854 provided in this section;

1855 (f) Define and determine the scope, duration and amount
1856 of Medicaid that may be provided in accordance with this article
1857 and establish priorities therefor in conformity with this article;

1858 (g) Cooperate and contract with other state agencies
1859 for the purpose of coordinating Medicaid provided under this

1860 article and eliminating duplication and inefficiency in the
1861 Medicaid program;

1862 (h) Adopt and use an official seal of the division;

1863 (i) Sue in its own name on behalf of the State of
1864 Mississippi and employ legal counsel on a contingency basis with
1865 the approval of the Attorney General;

1866 (j) To recover any and all payments incorrectly made by
1867 the division to a recipient or provider from the recipient or
1868 provider receiving the payments. To recover those payments, the
1869 division may use the following methods, in addition to any other
1870 methods available to the division:

1871 (i) The division shall report to the State Tax
1872 Commission the name of any current or former Medicaid recipient
1873 who has received medical services rendered during a period of
1874 established Medicaid ineligibility and who has not reimbursed the
1875 division for the related medical service payment(s). The State
1876 Tax Commission shall withhold from the state tax refund of the
1877 individual, and pay to the division, the amount of the payment(s)
1878 for medical services rendered to the ineligible individual that
1879 have not been reimbursed to the division for the related medical
1880 service payment(s).

1881 (ii) The division shall report to the State Tax
1882 Commission the name of any Medicaid provider to whom payments were
1883 incorrectly made that the division has not been able to recover by
1884 other methods available to the division. The State Tax Commission
1885 shall withhold from the state tax refund of the provider, and pay
1886 to the division, the amount of the payments that were incorrectly
1887 made to the provider that have not been recovered by other
1888 available methods;

1889 (k) To recover any and all payments by the division
1890 fraudulently obtained by a recipient or provider. Additionally,
1891 if recovery of any payments fraudulently obtained by a recipient
1892 or provider is made in any court, then, upon motion of the

1893 Governor, the judge of the court may award twice the payments
1894 recovered as damages;
1895 (l) Have full, complete and plenary power and authority
1896 to conduct such investigations as it may deem necessary and
1897 requisite of alleged or suspected violations or abuses of the
1898 provisions of this article or of the regulations adopted under
1899 this article, including, but not limited to, fraudulent or
1900 unlawful act or deed by applicants for Medicaid or other benefits,
1901 or payments made to any person, firm or corporation under the
1902 terms, conditions and authority of this article, to suspend or
1903 disqualify any provider of services, applicant or recipient for
1904 gross abuse, fraudulent or unlawful acts for such periods,
1905 including permanently, and under such conditions as the division
1906 deems proper and just, including the imposition of a legal rate of
1907 interest on the amount improperly or incorrectly paid. Recipients
1908 who are found to have misused or abused Medicaid benefits may be
1909 locked into one (1) physician and/or one (1) pharmacy of the
1910 recipient's choice for a reasonable amount of time in order to
1911 educate and promote appropriate use of medical services, in
1912 accordance with federal regulations. If an administrative hearing
1913 becomes necessary, the division may, if the provider does not
1914 succeed in his or her defense, tax the costs of the administrative
1915 hearing, including the costs of the court reporter or stenographer
1916 and transcript, to the provider. The convictions of a recipient
1917 or a provider in a state or federal court for abuse, fraudulent or
1918 unlawful acts under this chapter shall constitute an automatic
1919 disqualification of the recipient or automatic disqualification of
1920 the provider from participation under the Medicaid program.
1921 A conviction, for the purposes of this chapter, shall include
1922 a judgment entered on a plea of nolo contendere or a
1923 nonadjudicated guilty plea and shall have the same force as a
1924 judgment entered pursuant to a guilty plea or a conviction
1925 following trial. A certified copy of the judgment of the court of

1926 competent jurisdiction of the conviction shall constitute prima
1927 facie evidence of the conviction for disqualification purposes;
1928 (m) Establish and provide such methods of
1929 administration as may be necessary for the proper and efficient
1930 operation of the Medicaid program, fully utilizing computer
1931 equipment as may be necessary to oversee and control all current
1932 expenditures for purposes of this article, and to closely monitor
1933 and supervise all recipient payments and vendors rendering
1934 services under this article;
1935 (n) To cooperate and contract with the federal
1936 government for the purpose of providing Medicaid to Vietnamese and
1937 Cambodian refugees, under the provisions of Public Law 94-23 and
1938 Public Law 94-24, including any amendments to those laws, only to
1939 the extent that the Medicaid assistance and the administrative
1940 cost related thereto are one hundred percent (100%) reimbursable
1941 by the federal government. For the purposes of Section 43-13-117,
1942 persons receiving Medicaid under Public Law 94-23 and Public Law
1943 94-24, including any amendments to those laws, shall not be
1944 considered a new group or category of recipient; and
1945 (o) The division shall impose penalties upon Medicaid
1946 only, Title XIX participating long-term care facilities found to
1947 be in noncompliance with division and certification standards in
1948 accordance with federal and state regulations, including interest
1949 at the same rate calculated by the United States Department of
1950 Health and Human Services and/or the Centers for Medicare and
1951 Medicaid Services (CMS) under federal regulations.
1952 (2) The division also shall exercise such additional powers
1953 and perform such other duties as may be conferred upon the
1954 division by act of the Legislature.
1955 (3) The division, and the State Department of Health as the
1956 agency for licensure of health care facilities and certification
1957 and inspection for the Medicaid and/or Medicare programs, shall
1958 contract for or otherwise provide for the consolidation of on-site

1959 inspections of health care facilities that are necessitated by the
1960 respective programs and functions of the division and the
1961 department.

1962 (4) The division and its hearing officers shall have power
1963 to preserve and enforce order during hearings; to issue subpoenas
1964 for, to administer oaths to and to compel the attendance and
1965 testimony of witnesses, or the production of books, papers,
1966 documents and other evidence, or the taking of depositions before
1967 any designated individual competent to administer oaths; to
1968 examine witnesses; and to do all things conformable to law that
1969 may be necessary to enable them effectively to discharge the
1970 duties of their office. In compelling the attendance and
1971 testimony of witnesses, or the production of books, papers,
1972 documents and other evidence, or the taking of depositions, as
1973 authorized by this section, the division or its hearing officers
1974 may designate an individual employed by the division or some other
1975 suitable person to execute and return that process, whose action
1976 in executing and returning that process shall be as lawful as if
1977 done by the sheriff or some other proper officer authorized to
1978 execute and return process in the county where the witness may
1979 reside. In carrying out the investigatory powers under the
1980 provisions of this article, the executive director or other
1981 designated person or persons may examine, obtain, copy or
1982 reproduce the books, papers, documents, medical charts,
1983 prescriptions and other records relating to medical care and
1984 services furnished by the provider to a recipient or designated
1985 recipients of Medicaid services under investigation. In the
1986 absence of the voluntary submission of the books, papers,
1987 documents, medical charts, prescriptions and other records, the
1988 Governor, the executive director, or other designated person may
1989 issue and serve subpoenas instantly upon the provider, his or her
1990 agent, servant or employee for the production of the books,
1991 papers, documents, medical charts, prescriptions or other records

1992 during an audit or investigation of the provider. If any provider
1993 or his or her agent, servant or employee refuses to produce the
1994 records after being duly subpoenaed, the executive director may
1995 certify those facts and institute contempt proceedings in the
1996 manner, time and place as authorized by law for administrative
1997 proceedings. As an additional remedy, the division may recover
1998 all amounts paid to the provider covering the period of the audit
1999 or investigation, inclusive of a legal rate of interest and a
2000 reasonable attorney's fee and costs of court if suit becomes
2001 necessary. Division staff shall have immediate access to the
2002 provider's physical location, facilities, records, documents,
2003 books, and any other records relating to medical care and services
2004 rendered to recipients during regular business hours.
2005 (5) If any person in proceedings before the division
2006 disobeys or resists any lawful order or process, or misbehaves
2007 during a hearing or so near the place thereof as to obstruct the
2008 hearing, or neglects to produce, after having been ordered to do
2009 so, any pertinent book, paper or document, or refuses to appear
2010 after having been subpoenaed, or upon appearing refuses to take
2011 the oath as a witness, or after having taken the oath refuses to
2012 be examined according to law, the executive director shall certify
2013 the facts to any court having jurisdiction in the place in which
2014 it is sitting, and the court shall thereupon, in a summary manner,
2015 hear the evidence as to the acts complained of, and if the
2016 evidence so warrants, punish that person in the same manner and to
2017 the same extent as for a contempt committed before the court, or
2018 commit that person upon the same condition as if the doing of the
2019 forbidden act had occurred with reference to the process of, or in
2020 the presence of, the court.
2021 (6) In suspending or terminating any provider from
2022 participation in the Medicaid program, the division shall preclude
2023 the provider from submitting claims for payment, either personally
2024 or through any clinic, group, corporation or other association to

2025 the division or its fiscal agents for any services or supplies
2026 provided under the Medicaid program except for those services or
2027 supplies provided before the suspension or termination. No
2028 clinic, group, corporation or other association that is a provider
2029 of services shall submit claims for payment to the division or its
2030 fiscal agents for any services or supplies provided by a person
2031 within that organization who has been suspended or terminated from
2032 participation in the Medicaid program except for those services or
2033 supplies provided before the suspension or termination. When this
2034 provision is violated by a provider of services that is a clinic,
2035 group, corporation or other association, the division may suspend
2036 or terminate that organization from participation. Suspension may
2037 be applied by the division to all known affiliates of a provider,
2038 provided that each decision to include an affiliate is made on a
2039 case-by-case basis after giving due regard to all relevant facts
2040 and circumstances. The violation, failure or inadequacy of
2041 performance may be imputed to a person with whom the provider is
2042 affiliated where that conduct was accomplished within the course
2043 of his or her official duty or was effectuated by him or her with
2044 the knowledge or approval of that person.
2045 (7) The division may deny or revoke enrollment in the
2046 Medicaid program to a provider if any of the following are found
2047 to be applicable to the provider, his or her agent, a managing
2048 employee or any person having an ownership interest equal to five
2049 percent (5%) or greater in the provider:
2050 (a) Failure to truthfully or fully disclose any and all
2051 information required, or the concealment of any and all
2052 information required, on a claim, a provider application or a
2053 provider agreement, or the making of a false or misleading
2054 statement to the division relative to the Medicaid program.
2055 (b) Previous or current exclusion, suspension,
2056 termination from or the involuntary withdrawing from participation
2057 in the Medicaid program, any other state's Medicaid program,

2058 Medicare or any other public or private health or health insurance
2059 program. If the division ascertains that a provider has been
2060 convicted of a felony under federal or state law for an offense
2061 that the division determines is detrimental to the best interest
2062 of the program or of Medicaid beneficiaries, the division may
2063 refuse to enter into an agreement with that provider, or may
2064 terminate or refuse to renew an existing agreement.
2065 (c) Conviction under federal or state law of a criminal
2066 offense relating to the delivery of any goods, services or
2067 supplies, including the performance of management or
2068 administrative services relating to the delivery of the goods,
2069 services or supplies, under the Medicaid program, any other
2070 state's Medicaid program, Medicare or any other public or private
2071 health or health insurance program.
2072 (d) Conviction under federal or state law of a criminal
2073 offense relating to the neglect or abuse of a patient in
2074 connection with the delivery of any goods, services or supplies.
2075 (e) Conviction under federal or state law of a criminal
2076 offense relating to the unlawful manufacture, distribution,
2077 prescription or dispensing of a controlled substance.
2078 (f) Conviction under federal or state law of a criminal
2079 offense relating to fraud, theft, embezzlement, breach of
2080 fiduciary responsibility or other financial misconduct.
2081 (g) Conviction under federal or state law of a criminal
2082 offense punishable by imprisonment of a year or more that involves
2083 moral turpitude, or acts against the elderly, children or infirm.
2084 (h) Conviction under federal or state law of a criminal
2085 offense in connection with the interference or obstruction of any
2086 investigation into any criminal offense listed in paragraphs (c)
2087 through (i) of this subsection.
2088 (i) Sanction for a violation of federal or state laws
2089 or rules relative to the Medicaid program, any other state's

2090 Medicaid program, Medicare or any other public health care or
2091 health insurance program.
2092 (j) Revocation of license or certification.
2093 (k) Failure to pay recovery properly assessed or
2094 pursuant to an approved repayment schedule under the Medicaid
2095 program.
2096 (l) Failure to meet any condition of enrollment.
2097 **SECTION 8.** Section 43-13-122, Mississippi Code of 1972, is
2098 brought forward as follows:
2099 43-13-122. (1) The division is authorized to apply to the
2100 Center for Medicare and Medicaid Services of the United States
2101 Department of Health and Human Services for waivers and research
2102 and demonstration grants.
2103 (2) The division is further authorized to accept and expend
2104 any grants, donations or contributions from any public or private
2105 organization together with any additional federal matching funds
2106 that may accrue and, including, but not limited to, one hundred
2107 percent (100%) federal grant funds or funds from any governmental
2108 entity or instrumentality thereof in furthering the purposes and
2109 objectives of the Mississippi Medicaid program, provided that such
2110 receipts and expenditures are reported and otherwise handled in
2111 accordance with the General Fund Stabilization Act. The
2112 Department of Finance and Administration is authorized to transfer
2113 monies to the division from special funds in the State Treasury in
2114 amounts not exceeding the amounts authorized in the appropriation
2115 to the division.
2116 **SECTION 9.** Section 43-13-123, Mississippi Code of 1972, is
2117 brought forward as follows:
2118 43-13-123. The determination of the method of providing
2119 payment of claims under this article shall be made by the
2120 division, with approval of the Governor, which methods may be:
2121 (a) By contract with insurance companies licensed to do
2122 business in the State of Mississippi or with nonprofit hospital

2123 service corporations, medical or dental service corporations,
2124 authorized to do business in Mississippi to underwrite on an
2125 insured premium approach, such medical assistance benefits as may
2126 be available, and any carrier selected under the provisions of
2127 this article is expressly authorized and empowered to undertake
2128 the performance of the requirements of that contract.

2129 (b) By contract with an insurance company licensed to
2130 do business in the State of Mississippi or with nonprofit hospital
2131 service, medical or dental service organizations, or other
2132 organizations including data processing companies, authorized to
2133 do business in Mississippi to act as fiscal agent.

2134 The division shall obtain services to be provided under
2135 either of the above-described provisions in accordance with the
2136 Personal Service Contract Review Board Procurement Regulations.

2137 The authorization of the foregoing methods shall not preclude
2138 other methods of providing payment of claims through direct
2139 operation of the program by the state or its agencies.

2140 **SECTION 10.** Section 43-13-125, Mississippi Code of 1972, is
2141 brought forward as follows:

2142 43-13-125. (1) If Medicaid is provided to a recipient under
2143 this article for injuries, disease or sickness caused under
2144 circumstances creating a cause of action in favor of the recipient
2145 against any person, firm or corporation, then the division shall
2146 be entitled to recover the proceeds that may result from the
2147 exercise of any rights of recovery that the recipient may have
2148 against any such person, firm or corporation to the extent of the
2149 Division of Medicaid's interest on behalf of the recipient. The
2150 recipient shall execute and deliver instruments and papers to do
2151 whatever is necessary to secure those rights and shall do nothing
2152 after Medicaid is provided to prejudice the subrogation rights of
2153 the division. Court orders or agreements for reimbursement of
2154 Medicaid's interest shall direct those payments to the Division of
2155 Medicaid, which shall be authorized to endorse any and all,

2156 including, but not limited to, multi-payee checks, drafts, money
2157 orders, or other negotiable instruments representing Medicaid
2158 payment recoveries that are received. In accordance with Section
2159 43-13-305, endorsement of multi-payee checks, drafts, money orders
2160 or other negotiable instruments by the Division of Medicaid shall
2161 be deemed endorsed by the recipient.

2162 The division, with the approval of the Governor, may
2163 compromise or settle any such claim and execute a release of any
2164 claim it has by virtue of this section.

2165 (2) The acceptance of Medicaid under this article or the
2166 making of a claim under this article shall not affect the right of
2167 a recipient or his or her legal representative to recover
2168 Medicaid's interest as an element of damages in any action at law;
2169 however, a copy of the pleadings shall be certified to the
2170 division at the time of the institution of suit, and proof of
2171 that notice shall be filed of record in that action. The division
2172 may, at any time before the trial on the facts, join in that
2173 action or may intervene in that action. Any amount recovered by a
2174 recipient or his or her legal representative shall be applied as
2175 follows:

2176 (a) The reasonable costs of the collection, including
2177 attorney's fees, as approved and allowed by the court in which
2178 that action is pending, or in case of settlement without suit, by
2179 the legal representative of the division;

2180 (b) The amount of Medicaid's interest on behalf of the
2181 recipient; or such pro rata amount as may be arrived at by the
2182 legal representative of the division and the recipient's attorney,
2183 or as set by the court having jurisdiction; and

2184 (c) Any excess shall be awarded to the recipient.

2185 (3) No compromise of any claim by the recipient or his or
2186 her legal representative shall be binding upon or affect the
2187 rights of the division against the third party unless the
2188 division, with the approval of the Governor, has entered into the

2189 compromise. Any compromise effected by the recipient or his or
2190 her legal representative with the third party in the absence of
2191 advance notification to and approved by the division shall
2192 constitute conclusive evidence of the liability of the third
2193 party, and the division, in litigating its claim against the third
2194 party, shall be required only to prove the amount and correctness
2195 of its claim relating to the injury, disease or sickness. If the
2196 recipient or his or her legal representative fails to notify the
2197 division of the institution of legal proceedings against a third
2198 party for which the division has a cause of action, the facts
2199 relating to negligence and the liability of the third party, if
2200 judgment is rendered for the recipient, shall constitute
2201 conclusive evidence of liability in a subsequent action maintained
2202 by the division and only the amount and correctness of the
2203 division's claim relating to injuries, disease or sickness shall
2204 be tried before the court. The division shall be authorized in
2205 bringing that action against the third party and his or her
2206 insurer jointly or against the insurer alone.

2207 (4) Nothing in this section shall be construed to diminish
2208 or otherwise restrict the subrogation rights of the Division of
2209 Medicaid against a third party for Medicaid provided by the
2210 Division of Medicaid to the recipient as a result of injuries,
2211 disease or sickness caused under circumstances creating a cause of
2212 action in favor of the recipient against such a third party.

2213 (5) Any amounts recovered by the division under this section
2214 shall, by the division, be placed to the credit of the funds
2215 appropriated for benefits under this article proportionate to the
2216 amounts provided by the state and federal governments
2217 respectively.

2218 **SECTION 11.** Section 43-13-127, Mississippi Code of 1972, is
2219 brought forward as follows:

2220 43-13-127. (1) Within sixty (60) days after the end of each
2221 fiscal year and at each regular session of the Legislature, the

2222 division shall make and publish a report to the Governor and to
2223 the Legislature, showing for the period of time covered the
2224 following:
2225 (a) The total number of recipients;
2226 (b) The total amount paid for medical assistance and
2227 care under this article;
2228 (c) The total number of applications;
2229 (d) The number of applications approved;
2230 (e) The number of applications denied;
2231 (f) The amount expended for administration of the
2232 provisions of this article;
2233 (g) The amount of money received from the federal
2234 government, if any;
2235 (h) The amount of money recovered by reason of
2236 collections from third persons by reason of assignment or
2237 subrogation, and the disposition of the same;
2238 (i) The actions and activities of the division in
2239 detecting and investigating suspected or alleged fraudulent
2240 practices, violations and abuses of the program; and
2241 (j) Any recommendations it may have as to expanding,
2242 enlarging, limiting or restricting the eligibility of persons
2243 covered by this article or services provided by this article, to
2244 make more effective the basic purposes of this article; to
2245 eliminate or curtail fraudulent practices and inequities in the
2246 plan or administration thereof; and to continue to participate in
2247 receiving federal funds for the furnishing of medical assistance
2248 under Title XIX of the Social Security Act or other federal law.
2249 (2) In addition to the reports required by subsection (1) of
2250 this section, the division shall submit a report each month to the
2251 Chairmen of the Public Health and Welfare Committees of the Senate
2252 and the House of Representatives and to the Joint Legislative
2253 Budget Committee that contains the information specified in each
2254 paragraph of subsection (1) for the preceding month.

2255 **SECTION 12.** Section 43-13-129, Mississippi Code of 1972, is
2256 brought forward as follows:
2257 43-13-129. Any person making application for benefits under
2258 this article for himself or for another person, and any provider
2259 of services, who knowingly makes a false statement or false
2260 representation or fails to disclose a material fact to obtain or
2261 increase any benefit or payment under this article shall be guilty
2262 of a misdemeanor and, upon conviction thereof, shall be punished
2263 by a fine not to exceed five hundred dollars ($500.00) or
2264 imprisoned not to exceed one (1) year, or by both such fine and
2265 imprisonment. Each false statement or false representation or
2266 failure to disclose a material fact shall constitute a separate
2267 offense. This section shall not prohibit prosecution under any
2268 other criminal statutes of this state or the United States.
2269 **SECTION 13.** Section 43-13-139, Mississippi Code of 1972, is
2270 brought forward as follows:
2271 43-13-139. Nothing contained in this article shall be
2272 construed to prevent the Governor, in his discretion, from
2273 discontinuing or limiting medical assistance to any individuals
2274 who are classified or deemed to be within any optional group or
2275 optional category of recipients as prescribed under Title XIX of
2276 the federal Social Security Act or the implementing federal
2277 regulations. If the Congress or the United States Department of
2278 Health and Human Services ceases to provide federal matching funds
2279 for any group or category of recipients or any type of care and
2280 services, the division shall cease state funding for such group or
2281 category or such type of care and services, notwithstanding any
2282 provision of this article.
2283 **SECTION 14.** Section 43-13-143, Mississippi Code of 1972, is
2284 brought forward as follows:
2285 43-13-143. There is created in the State Treasury a special
2286 fund to be known as the "Medical Care Fund," which shall be
2287 comprised of monies transferred by public or private health care

2288 providers, governing bodies of counties, municipalities, public or
2289 community hospitals and other political subdivisions of the state,
2290 individuals, corporations, associations and any other entities for
2291 the purpose of providing health care services. Any transfer made
2292 to the fund shall be paid to the State Treasurer for deposit into
2293 the fund, and all such transfers shall be considered as
2294 unconditional transfers to the fund. The monies in the Medical
2295 Care Fund shall be expended only for health care services, and may
2296 be expended only upon appropriation of the Legislature. All
2297 transfers of monies to the Division of Medicaid by health care
2298 providers and by governing bodies of counties, municipalities,
2299 public or community hospitals and other political subdivisions of
2300 the state shall be deposited into the fund. Unexpended monies
2301 remaining in the fund at the end of a fiscal year shall not lapse
2302 into the State General Fund, and any interest earned on monies in
2303 the fund shall be deposited to the credit of the fund.

2304 **SECTION 15.** Section 43-13-145, Mississippi Code of 1972, is
2305 brought forward as follows:

2306 43-13-145. (1) (a) Upon each nursing facility licensed by
2307 the State of Mississippi, there is levied an assessment in an
2308 amount set by the division, not exceeding the maximum rate allowed
2309 by federal law or regulation, for each licensed and occupied bed
2310 of the facility.

2311 (b) A nursing facility is exempt from the assessment
2312 levied under this subsection if the facility is operated under the
2313 direction and control of:

2314 (i) The United States Veterans Administration or
2315 other agency or department of the United States government;

2316 (ii) The State Veterans Affairs Board;

2317 (iii) The University of Mississippi Medical
2318 Center; or

2319 (iv) A state agency or a state facility that
2320 either provides its own state match through intergovernmental
2321 transfer or certification of funds to the division.
2322 (2) (a) Upon each intermediate care facility for the
2323 mentally retarded licensed by the State of Mississippi, there is
2324 levied an assessment in an amount set by the division, not
2325 exceeding the maximum rate allowed by federal law or regulation,
2326 for each licensed and occupied bed of the facility.
2327 (b) An intermediate care facility for the mentally
2328 retarded is exempt from the assessment levied under this
2329 subsection if the facility is operated under the direction and
2330 control of:
2331 (i) The United States Veterans Administration or
2332 other agency or department of the United States government;
2333 (ii) The State Veterans Affairs Board; or
2334 (iii) The University of Mississippi Medical
2335 Center.
2336 (3) (a) Upon each psychiatric residential treatment
2337 facility licensed by the State of Mississippi, there is levied an
2338 assessment in an amount set by the division, not exceeding the
2339 maximum rate allowed by federal law or regulation, for each
2340 licensed and occupied bed of the facility.
2341 (b) A psychiatric residential treatment facility is
2342 exempt from the assessment levied under this subsection if the
2343 facility is operated under the direction and control of:
2344 (i) The United States Veterans Administration or
2345 other agency or department of the United States government;
2346 (ii) The University of Mississippi Medical Center;
2347 (iii) A state agency or a state facility that
2348 either provides its own state match through intergovernmental
2349 transfer or certification of funds to the division.
2350 (4) (a) Upon each hospital licensed by the State of
2351 Mississippi, there is levied an assessment in the amount of Three

2352 Dollars and Twenty-five Cents ($3.25) per bed for each licensed
2353 inpatient acute care bed of the hospital.
2354 (b) A hospital is exempt from the assessment levied
2355 under this subsection if the hospital is operated under the
2356 direction and control of:
2357 (i) The United States Veterans Administration or
2358 other agency or department of the United States government;
2359 (ii) The University of Mississippi Medical Center;
2360 or
2361 (iii) A state agency or a state facility that
2362 either provides its own state match through intergovernmental
2363 transfer or certification of funds to the division.
2364 (5) Each health care facility that is subject to the
2365 provisions of this section shall keep and preserve such suitable
2366 books and records as may be necessary to determine the amount of
2367 assessment for which it is liable under this section. The books
2368 and records shall be kept and preserved for a period of not less
2369 than five (5) years, and those books and records shall be open for
2370 examination during business hours by the division, the State Tax
2371 Commission, the Office of the Attorney General and the State
2372 Department of Health.
2373 (6) The assessment levied under this section shall be
2374 collected by the division each month beginning on March 31, 2005.
2375 (7) All assessments collected under this section shall be
2376 deposited in the Medical Care Fund created by Section 43-13-143.
2377 (8) The assessment levied under this section shall be in
2378 addition to any other assessments, taxes or fees levied by law,
2379 and the assessment shall constitute a debt due the State of
2380 Mississippi from the time the assessment is due until it is paid.
2381 (9) (a) If a health care facility that is liable for
2382 payment of an assessment levied by the division does not pay the
2383 assessment when it is due, the division shall give written notice
2384 to the health care facility by certified or registered mail

2385 demanding payment of the assessment within ten (10) days from the
2386 date of delivery of the notice. If the health care facility
2387 fails or refuses to pay the assessment after receiving the notice
2388 and demand from the division, the division shall withhold from any
2389 Medicaid reimbursement payments that are due to the health care
2390 facility the amount of the unpaid assessment and a penalty of ten
2391 percent (10%) of the amount of the assessment, plus the legal rate
2392 of interest until the assessment is paid in full. If the health
2393 care facility does not participate in the Medicaid program, the
2394 division shall turn over to the Office of the Attorney General the
2395 collection of the unpaid assessment by civil action. In any such
2396 civil action, the Office of the Attorney General shall collect the
2397 amount of the unpaid assessment and a penalty of ten percent (10%)
2398 of the amount of the assessment, plus the legal rate of interest
2399 until the assessment is paid in full.

2400 (b) As an additional or alternative method for
2401 collecting unpaid assessments levied by the division, if a health
2402 care facility fails or refuses to pay the assessment after
2403 receiving notice and demand from the division, the division may
2404 file a notice of a tax lien with the circuit clerk of the county
2405 in which the health care facility is located, for the amount of
2406 the unpaid assessment and a penalty of ten percent (10%) of the
2407 amount of the assessment, plus the legal rate of interest until
2408 the assessment is paid in full. Immediately upon receipt of
2409 notice of the tax lien for the assessment, the circuit clerk shall
2410 enter the notice of the tax lien as a judgment upon the judgment
2411 roll and show in the appropriate columns the name of the health
2412 care facility as judgment debtor, the name of the division as
2413 judgment creditor, the amount of the unpaid assessment, and the
2414 date and time of enrollment. The judgment shall be valid as
2415 against mortgagees, pledgees, entrusters, purchasers, judgment
2416 creditors and other persons from the time of filing with the
2417 clerk. The amount of the judgment shall be a debt due the State

2418 of Mississippi and remain a lien upon the tangible property of the
2419 health care facility until the judgment is satisfied. The
2420 judgment shall be the equivalent of any enrolled judgment of a
2421 court of record and shall serve as authority for the issuance of
2422 writs of execution, writs of attachment or other remedial writs.
2423 **SECTION 16.** This act shall take effect and be in force from
2424 and after July 1, 2007.

ST: Medicaid; bring forward certain sections for purpose of amendment.