By: Representative Flaggs To: Medicaid; Ways and Means

HOUSE BILL NO. 371

1 AN ACT TO BRING FORWARD SECTIONS 43-13-101, 43-13-103,
2 43-13-105, 43-13-107, 43-13-109, 43-13-111, 43-13-113, 43-13-115,
3 43-13-116, 43-13-117, 43-13-117.1, 43-13-117.2, 43-13-117.3,
4 43-13-118, 43-13-120, 43-13-121, 43-13-122, 43-13-123, 43-13-125,
5 43-13-126, 43-13-127, 43-13-129, 43-13-131, 43-13-133, 43-13-137,
6 43-13-139, 43-13-143 AND 43-13-145, MISSISSIPPI CODE OF 1972, OF
7 THE MISSISSIPPI MEDICAID LAW, FOR THE PURPOSES OF AMENDMENT; TO
8 AMEND SECTION 27-69-13, MISSISSIPPI CODE OF 1972, TO INCREASE THE
9 EXCISE TAX ON CIGARETTES; TO AMEND SECTION 27-69-75, MISSISSIPPI
10 CODE OF 1972, TO PROVIDE THAT THE REVENUE DERIVED FROM THE TAX
11 INCREASE PROVIDED FOR BY THE PRECEDING SECTION SHALL BE DEPOSITED
12 INTO THE HEALTH CARE EXPENDABLE FUND, THE MISSISSIPPI TRAUMA CARE
13 SYSTEMS FUND AND INTO A SPECIAL FUND IN THE STATE TREASURY TO THE
14 CREDIT OF THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER; AND FOR
15 RELATED PURPOSES.

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

17 **SECTION 1.** Section 43-13-101, Mississippi Code of 1972, is
18 brought forward as follows:

19 43-13-101. This article shall be entitled and cited as the
20 "Mississippi Medicaid Law."

21 **SECTION 2.** Section 43-13-103, Mississippi Code of 1972, is
22 brought forward as follows:

23 43-13-103. For the purpose of affording health care and
24 remedial and institutional services in accordance with the
25 requirements for federal grants and other assistance under Titles
26 XVIII, XIX and XXI of the Social Security Act, as amended, a
27 statewide system of medical assistance is established and shall be
28 in effect in all political subdivisions of the state, to be
29 financed by state appropriations and federal matching funds
30 therefor, and to be administered by the Office of the Governor as
31 hereinafter provided.

32 **SECTION 3.** Section 43-13-105, Mississippi Code of 1972, is
33 brought forward as follows:
34 43-13-105. When used in this article, the following
35 definitions shall apply, unless the context requires otherwise:
36 (a) "Administering agency" means the Division of
37 Medicaid in the Office of the Governor as created by this article.
38 (b) "Division" or "Division of Medicaid" means the
39 Division of Medicaid in the Office of the Governor.
40 (c) "Medical assistance" means payment of part or all
41 of the costs of medical and remedial care provided under the terms
42 of this article and in accordance with provisions of Titles XIX
43 and XXI of the Social Security Act, as amended.
44 (d) "Applicant" means a person who applies for
45 assistance under Titles IV, XVI, XIX or XXI of the Social Security
46 Act, as amended, and under the terms of this article.
47 (e) "Recipient" means a person who is eligible for
48 assistance under Title XIX or XXI of the Social Security Act, as
49 amended and under the terms of this article.
50 (f) "State health agency" shall mean any agency,
51 department, institution, board or commission of the State of
52 Mississippi, except the University Medical School, which is
53 supported in whole or in part by any public funds, including funds
54 directly appropriated from the State Treasury, funds derived by
55 taxes, fees levied or collected by statutory authority, or any
56 other funds used by "state health agencies" derived from federal
57 sources, when any funds available to such agency are expended
58 either directly or indirectly in connection with, or in support
59 of, any public health, hospital, hospitalization or other public
60 programs for the preventive treatment or actual medical treatment
61 of persons who are physically or mentally ill or mentally
62 retarded.
63 (g) "Mississippi Medicaid Commission" or "Medicaid
64 Commission" wherever they appear in the laws of the State of

65 Mississippi, shall mean the Division of Medicaid in the Office of
66 the Governor.

67 **SECTION 4.** Section 43-13-107, Mississippi Code of 1972, is
68 brought forward as follows:

69 43-13-107. (1) The Division of Medicaid is created in the
70 Office of the Governor and established to administer this article
71 and perform such other duties as are prescribed by law.

72 (2) (a) The Governor shall appoint a full-time executive
73 director, with the advice and consent of the Senate, who shall be
74 either (i) a physician with administrative experience in a medical
75 care or health program, or (ii) a person holding a graduate degree
76 in medical care administration, public health, hospital
77 administration, or the equivalent, or (iii) a person holding a
78 bachelor's degree in business administration or hospital
79 administration, with at least ten (10) years' experience in
80 management-level administration of Medicaid programs. The
81 executive director shall be the official secretary and legal
82 custodian of the records of the division; shall be the agent of
83 the division for the purpose of receiving all service of process,
84 summons and notices directed to the division; shall perform such
85 other duties as the Governor may prescribe from time to time; and
86 shall perform all other duties that are now or may be imposed upon
87 him or her by law.

88 (b) The executive director shall serve at the will and
89 pleasure of the Governor.

90 (c) The executive director shall, before entering upon
91 the discharge of the duties of the office, take and subscribe to
92 the oath of office prescribed by the Mississippi Constitution and
93 shall file the same in the Office of the Secretary of State, and
94 shall execute a bond in some surety company authorized to do
95 business in the state in the penal sum of One Hundred Thousand
96 Dollars ($100,000.00), conditioned for the faithful and impartial
97 discharge of the duties of the office. The premium on the bond

98 shall be paid as provided by law out of funds appropriated to the
99 Division of Medicaid for contractual services.
100 (d) The executive director, with the approval of the
101 Governor and subject to the rules and regulations of the State
102 Personnel Board, shall employ such professional, administrative,
103 stenographic, secretarial, clerical and technical assistance as
104 may be necessary to perform the duties required in administering
105 this article and fix the compensation for those persons, all in
106 accordance with a state merit system meeting federal requirements.
107 When the salary of the executive director is not set by law, that
108 salary shall be set by the State Personnel Board. No employees of
109 the Division of Medicaid shall be considered to be staff members
110 of the immediate Office of the Governor; however, the provisions
111 of Section 25-9-107(c)(xv) shall apply to the executive director
112 and other administrative heads of the division.
113 (3) (a) There is established a Medical Care Advisory
114 Committee, which shall be the committee that is required by
115 federal regulation to advise the Division of Medicaid about health
116 and medical care services.
117 (b) The advisory committee shall consist of not less
118 than eleven (11) members, as follows:
119 (i) The Governor shall appoint five (5) members,
120 one (1) from each congressional district and one (1) from the
121 state at large;
122 (ii) The Lieutenant Governor shall appoint three
123 (3) members, one (1) from each Supreme Court district;
124 (iii) The Speaker of the House of Representatives
125 shall appoint three (3) members, one (1) from each Supreme Court
126 district.
127 All members appointed under this paragraph shall either be
128 health care providers or consumers of health care services. One
129 (1) member appointed by each of the appointing authorities shall
130 be a board certified physician.

131 (c) The respective Chairmen of the House Medicaid
132 Committee, the House Public Health and Human Services Committee,
133 the House Appropriations Committee, the Senate Public Health and
134 Welfare Committee and the Senate Appropriations Committee, or
135 their designees, two (2) members of the State Senate appointed by
136 the Lieutenant Governor and one (1) member of the House of
137 Representatives appointed by the Speaker of the House, shall serve
138 as ex officio nonvoting members of the advisory committee.

139 (d) In addition to the committee members required by
140 paragraph (b), the advisory committee shall consist of such other
141 members as are necessary to meet the requirements of the federal
142 regulation applicable to the advisory committee, who shall be
143 appointed as provided in the federal regulation.

144 (e) The chairmanship of the advisory committee shall be
145 elected by the voting members of the committee annually and shall
146 not serve more than two (2) consecutive years as chairman.

147 (f) The members of the advisory committee specified in
148 paragraph (b) shall serve for terms that are concurrent with the
149 terms of members of the Legislature, and any member appointed
150 under paragraph (b) may be reappointed to the advisory committee.
151 The members of the advisory committee specified in paragraph (b)
152 shall serve without compensation, but shall receive reimbursement
153 to defray actual expenses incurred in the performance of committee
154 business as authorized by law. Legislators shall receive per diem
155 and expenses, which may be paid from the contingent expense funds
156 of their respective houses in the same amounts as provided for
157 committee meetings when the Legislature is not in session.

158 (g) The advisory committee shall meet not less than
159 quarterly, and advisory committee members shall be furnished
160 written notice of the meetings at least ten (10) days before the
161 date of the meeting.

162 (h) The executive director shall submit to the advisory
163 committee all amendments, modifications and changes to the state

164 plan for the operation of the Medicaid program, for review by the
165 advisory committee before the amendments, modifications or changes
166 may be implemented by the division.

167 (i) The advisory committee, among its duties and
168 responsibilities, shall:

169 (i) Advise the division with respect to
170 amendments, modifications and changes to the state plan for the
171 operation of the Medicaid program;

172 (ii) Advise the division with respect to issues
173 concerning receipt and disbursement of funds and eligibility for
174 Medicaid;

175 (iii) Advise the division with respect to
176 determining the quantity, quality and extent of medical care
177 provided under this article;

178 (iv) Communicate the views of the medical care
179 professions to the division and communicate the views of the
180 division to the medical care professions;

181 (v) Gather information on reasons that medical
182 care providers do not participate in the Medicaid program and
183 changes that could be made in the program to encourage more
184 providers to participate in the Medicaid program, and advise the
185 division with respect to encouraging physicians and other medical
186 care providers to participate in the Medicaid program;

187 (vi) Provide a written report on or before
188 November 30 of each year to the Governor, Lieutenant Governor and
189 Speaker of the House of Representatives.

190 (4) (a) There is established a Drug Use Review Board, which
191 shall be the board that is required by federal law to:

192 (i) Review and initiate retrospective drug use,
193 review including ongoing periodic examination of claims data and
194 other records in order to identify patterns of fraud, abuse, gross
195 overuse, or inappropriate or medically unnecessary care, among

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

229 all documents provided to committee members shall be available to
230 members of the Legislature in the same manner, and shall be made
231 available to others for a reasonable fee for copying. However,
232 patient confidentiality and provider confidentiality shall be
233 protected by blinding patient names and provider names with
234 numerical or other anonymous identifiers. The committee meetings
235 shall be subject to the Open Meetings Act (Section 25-41-1 et
236 seq.). Committee meetings conducted in violation of this section
237 shall be deemed unlawful.

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

256 (e) Upon reviewing the information and recommendations,
257 the committee shall forward a written recommendation approved by a
258 majority of the committee to the executive director or his or her
259 designee. The decisions of the committee regarding any
260 limitations to be imposed on any drug or its use for a specified
261 indication shall be based on sound clinical evidence found in

262 labeling, drug compendia, and peer reviewed clinical literature
263 pertaining to use of the drug in the relevant population.
264 (f) Upon reviewing and considering all recommendations
265 including recommendation of the committee, comments, and data, the
266 executive director shall make a final determination whether to
267 require prior approval of a therapeutic class of drugs, or modify
268 existing prior approval requirements for a therapeutic class of
269 drugs.
270 (g) At least thirty (30) days before the executive
271 director implements new or amended prior authorization decisions,
272 written notice of the executive director's decision shall be
273 provided to all prescribing Medicaid providers, all Medicaid
274 enrolled pharmacies, and any other party who has requested the
275 notification. However, notice given under Section 25-43-7(1) will
276 substitute for and meet the requirement for notice under this
277 subsection.
278 (h) Members of the committee shall dispose of matters
279 before the committee in an unbiased and professional manner. If a
280 matter being considered by the committee presents a real or
281 apparent conflict of interest for any member of the committee,
282 that member shall disclose the conflict in writing to the
283 committee chair and recuse himself or herself from any discussions
284 and/or actions on the matter.
285 (6) This section shall stand repealed on July 1, 2009.
286 **SECTION 5.** Section 43-13-109, Mississippi Code of 1972, is
287 brought forward as follows:
288 43-13-109. The director, with the approval of the Governor
289 and pursuant to the rules and regulations of the State Personnel
290 Board, may adopt reasonable rules and regulations to provide for
291 an open, competitive or qualifying examination for all employees
292 of the division other than the director, part-time consultants and
293 professional staff members.

294 **SECTION 6.** Section 43-13-111, Mississippi Code of 1972, is
295 brought forward as follows:
296 43-13-111. Every state health agency, as defined in Section
297 43-13-105, shall obtain an appropriation of state funds from the
298 State Legislature for all medical assistance programs rendered by
299 the agency and shall organize its programs and budgets in such a
300 manner as to secure maximum federal funding through the Division
301 of Medicaid under Title XIX or Title XXI of the federal Social
302 Security Act, as amended.
303 **SECTION 7.** Section 43-13-113, Mississippi Code of 1972, is
304 brought forward as follows:
305 43-13-113. (1) The State Treasurer shall receive on behalf
306 of the state, and execute all instruments incidental thereto,
307 federal and other funds to be used for financing the medical
308 assistance plan or program adopted pursuant to this article, and
309 place all such funds in a special account to the credit of the
310 Governor's Office-Division of Medicaid, which funds shall be
311 expended by the division for the purposes and under the provisions
312 of this article, and shall be paid out by the State Treasurer as
313 funds appropriated to carry out the provisions of this article are
314 paid out by him.
315 The division shall issue all checks or electronic transfers
316 for administrative expenses, and for medical assistance under the
317 provisions of this article. All such checks or electronic
318 transfers shall be drawn upon funds made available to the division
319 by the State Auditor, upon requisition of the director. It is the
320 purpose of this section to provide that the State Auditor shall
321 transfer, in lump sums, amounts to the division for disbursement
322 under the regulations which shall be made by the director with the
323 approval of the Governor; however, the division, or its fiscal
324 agent in behalf of the division, shall be authorized in
325 maintaining separate accounts with a Mississippi bank to handle
326 claim payments, refund recoveries and related Medicaid program

327 financial transactions, to aggressively manage the float in these
328 accounts while awaiting clearance of checks or electronic
329 transfers and/or other disposition so as to accrue maximum
330 interest advantage of the funds in the account, and to retain all
331 earned interest on these funds to be applied to match federal
332 funds for Medicaid program operations.

333 (2) The division is authorized to obtain a line of credit
334 through the State Treasurer from the Working Cash-Stabilization
335 Fund or any other special source funds maintained in the State
336 Treasury in an amount not exceeding One Hundred Fifty Million
337 Dollars ($150,000,000.00) to fund shortfalls which, from time to
338 time, may occur due to decreases in state matching fund cash flow.
339 The length of indebtedness under this provision shall not carry
340 past the end of the quarter following the loan origination. Loan
341 proceeds shall be received by the State Treasurer and shall be
342 placed in a Medicaid designated special fund account. Loan
343 proceeds shall be expended only for health care services provided
344 under the Medicaid program. The division may pledge as security
345 for such interim financing future funds that will be received by
346 the division. Any such loans shall be repaid from the first
347 available funds received by the division in the manner of and
348 subject to the same terms provided in this section.

349 In the event the State Treasurer makes a determination that
350 special source funds are not sufficient to cover a line of credit
351 for the Division of Medicaid, the division is authorized to obtain
352 a line of credit, in an amount not exceeding One Hundred Fifty
353 Million Dollars ($150,000,000.00), from a commercial lender or a
354 consortium of lenders. The length of indebtedness under this
355 provision shall not carry past the end of the quarter following
356 the loan origination. The division shall obtain a minimum of two
357 (2) written quotes that shall be presented to the State Fiscal
358 Officer and State Treasurer, who shall jointly select a lender.
359 Loan proceeds shall be received by the State Treasurer and shall

360 be placed in a Medicaid designated special fund account. Loan
361 proceeds shall be expended only for health care services provided
362 under the Medicaid program. The division may pledge as security
363 for such interim financing future funds that will be received by
364 the division. Any such loans shall be repaid from the first
365 available funds received by the division in the manner of and
366 subject to the same terms provided in this section.

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

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

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

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

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

380 (e) If a claim is neither paid nor denied for valid and
381 proper reasons by the end of the time periods as specified above,
382 the Division of Medicaid's fiscal agent must pay the provider
383 interest on the claim at the rate of one and one-half percent
384 (1-1/2%) per month on the amount of such claim until it is finally
385 settled or adjudicated.

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

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

393 (6) The above specified time limitations do not apply in the
394 following circumstances:
395 (a) Retroactive adjustments paid to providers
396 reimbursed under a retrospective payment system;
397 (b) If a claim for payment under Medicare has been
398 filed in a timely manner, the fiscal agent may pay a Medicaid
399 claim relating to the same services within six (6) months after
400 it, or the provider, receives notice of the disposition of the
401 Medicare claim;
402 (c) Claims from providers under investigation for fraud
403 or abuse; and
404 (d) The Division of Medicaid and/or its fiscal agent
405 may make payments at any time in accordance with a court order, to
406 carry out hearing decisions or corrective actions taken to resolve
407 a dispute, or to extend the benefits of a hearing decision,
408 corrective action, or court order to others in the same situation
409 as those directly affected by it.
410 (7) Repealed.
411 (8) If sufficient funds are appropriated therefor by the
412 Legislature, the Division of Medicaid may contract with the
413 Mississippi Dental Association, or an approved designee, to
414 develop and operate a Donated Dental Services (DDS) program
415 through which volunteer dentists will treat needy disabled, aged
416 and medically compromised individuals who are non-Medicaid
417 eligible recipients.
418 **SECTION 8.** Section 43-13-115, Mississippi Code of 1972, is
419 brought forward as follows:
420 43-13-115. Recipients of Medicaid shall be the following
421 persons only:
422 (1) Those who are qualified for public assistance
423 grants under provisions of Title IV-A and E of the federal Social
424 Security Act, as amended, including those statutorily deemed to be
425 IV-A and low-income families and children under Section 1931 of

426 the federal Social Security Act. For the purposes of this
427 paragraph (1) and paragraphs (8), (17) and (18) of this section,
428 any reference to Title IV-A or to Part A of Title IV of the
429 federal Social Security Act, as amended, or the state plan under
430 Title IV-A or Part A of Title IV, shall be considered as a
431 reference to Title IV-A of the federal Social Security Act, as
432 amended, and the state plan under Title IV-A, including the income
433 and resource standards and methodologies under Title IV-A and the
434 state plan, as they existed on July 16, 1996. The Department of
435 Human Services shall determine Medicaid eligibility for children
436 receiving public assistance grants under Title IV-E. The division
437 shall determine eligibility for low-income families under Section
438 1931 of the federal Social Security Act and shall redetermine
439 eligibility for those continuing under Title IV-A grants.

440 (2) Those qualified for Supplemental Security Income
441 (SSI) benefits under Title XVI of the federal Social Security Act,
442 as amended, and those who are deemed SSI eligible as contained in
443 federal statute. The eligibility of individuals covered in this
444 paragraph shall be determined by the Social Security
445 Administration and certified to the Division of Medicaid.

446 (3) Qualified pregnant women who would be eligible for
447 Medicaid as a low-income family member under Section 1931 of the
448 federal Social Security Act if her child were born. The
449 eligibility of the individuals covered under this paragraph shall
450 be determined by the division.

451 (4) [Deleted]

452 (5) A child born on or after October 1, 1984, to a
453 woman eligible for and receiving Medicaid under the state plan on
454 the date of the child's birth shall be deemed to have applied for
455 Medicaid and to have been found eligible for Medicaid under the
456 plan on the date of that birth, and will remain eligible for
457 Medicaid for a period of one (1) year so long as the child is a
458 member of the woman's household and the woman remains eligible for

459 Medicaid or would be eligible for Medicaid if pregnant. The
460 eligibility of individuals covered in this paragraph shall be
461 determined by the Division of Medicaid.
462 (6) Children certified by the State Department of Human
463 Services to the Division of Medicaid of whom the state and county
464 departments of human services have custody and financial
465 responsibility, and children who are in adoptions subsidized in
466 full or part by the Department of Human Services, including
467 special needs children in non-Title IV-E adoption assistance, who
468 are approvable under Title XIX of the Medicaid program. The
469 eligibility of the children covered under this paragraph shall be
470 determined by the State Department of Human Services.
471 (7) Persons certified by the Division of Medicaid who
472 are patients in a medical facility (nursing home, hospital,
473 tuberculosis sanatorium or institution for treatment of mental
474 diseases), and who, except for the fact that they are patients in
475 that medical facility, would qualify for grants under Title IV,
476 Supplementary Security Income (SSI) benefits under Title XVI or
477 state supplements, and those aged, blind and disabled persons who
478 would not be eligible for Supplemental Security Income (SSI)
479 benefits under Title XVI or state supplements if they were not
480 institutionalized in a medical facility but whose income is below
481 the maximum standard set by the Division of Medicaid, which
482 standard shall not exceed that prescribed by federal regulation.
483 (8) Children under eighteen (18) years of age and
484 pregnant women (including those in intact families) who meet the
485 financial standards of the state plan approved under Title IV-A of
486 the federal Social Security Act, as amended. The eligibility of
487 children covered under this paragraph shall be determined by the
488 Division of Medicaid.
489 (9) Individuals who are:
490 (a) Children born after September 30, 1983, who
491 have not attained the age of nineteen (19), with family income

492 that does not exceed one hundred percent (100%) of the nonfarm
493 official poverty level;
494 (b) Pregnant women, infants and children who have
495 not attained the age of six (6), with family income that does not
496 exceed one hundred thirty-three percent (133%) of the federal
497 poverty level; and
498 (c) Pregnant women and infants who have not
499 attained the age of one (1), with family income that does not
500 exceed one hundred eighty-five percent (185%) of the federal
501 poverty level.
502 The eligibility of individuals covered in (a), (b) and (c) of
503 this paragraph shall be determined by the division.
504 (10) Certain disabled children age eighteen (18) or
505 under who are living at home, who would be eligible, if in a
506 medical institution, for SSI or a state supplemental payment under
507 Title XVI of the federal Social Security Act, as amended, and
508 therefore for Medicaid under the plan, and for whom the state has
509 made a determination as required under Section 1902(e)(3)(b) of
510 the federal Social Security Act, as amended. The eligibility of
511 individuals under this paragraph shall be determined by the
512 Division of Medicaid.
513 (11) Until the end of the day on December 31, 2005,
514 individuals who are sixty-five (65) years of age or older or are
515 disabled as determined under Section 1614(a)(3) of the federal
516 Social Security Act, as amended, and whose income does not exceed
517 one hundred thirty-five percent (135%) of the nonfarm official
518 poverty level as defined by the Office of Management and Budget
519 and revised annually, and whose resources do not exceed those
520 established by the Division of Medicaid. The eligibility of
521 individuals covered under this paragraph shall be determined by
522 the Division of Medicaid. After December 31, 2005, only those
523 individuals covered under the 1115(c) Healthier Mississippi waiver
524 will be covered under this category.

525 Any individual who applied for Medicaid during the period
526 from July 1, 2004, through March 31, 2005, who otherwise would
527 have been eligible for coverage under this paragraph (11) if it
528 had been in effect at the time the individual submitted his or her
529 application and is still eligible for coverage under this
530 paragraph (11) on March 31, 2005, shall be eligible for Medicaid
531 coverage under this paragraph (11) from March 31, 2005, through
532 December 31, 2005. The division shall give priority in processing
533 the applications for those individuals to determine their
534 eligibility under this paragraph (11).
535 (12) Individuals who are qualified Medicare
536 beneficiaries (QMB) entitled to Part A Medicare as defined under
537 Section 301, Public Law 100-360, known as the Medicare
538 Catastrophic Coverage Act of 1988, and whose income does not
539 exceed one hundred percent (100%) of the nonfarm official poverty
540 level as defined by the Office of Management and Budget and
541 revised annually.
542 The eligibility of individuals covered under this paragraph
543 shall be determined by the Division of Medicaid, and those
544 individuals determined eligible shall receive Medicare
545 cost-sharing expenses only as more fully defined by the Medicare
546 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
547 1997.
548 (13) (a) Individuals who are entitled to Medicare Part
549 A as defined in Section 4501 of the Omnibus Budget Reconciliation
550 Act of 1990, and whose income does not exceed one hundred twenty
551 percent (120%) of the nonfarm official poverty level as defined by
552 the Office of Management and Budget and revised annually.
553 Eligibility for Medicaid benefits is limited to full payment of
554 Medicare Part B premiums.
555 (b) Individuals entitled to Part A of Medicare,
556 with income above one hundred twenty percent (120%), but less than
557 one hundred thirty-five percent (135%) of the federal poverty

558 level, and not otherwise eligible for Medicaid Eligibility for
559 Medicaid benefits is limited to full payment of Medicare Part B
560 premiums. The number of eligible individuals is limited by the
561 availability of the federal capped allocation at one hundred
562 percent (100%) of federal matching funds, as more fully defined in
563 the Balanced Budget Act of 1997.

564 The eligibility of individuals covered under this paragraph
565 shall be determined by the Division of Medicaid.

566 (14) [Deleted]

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

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

582 (17) In accordance with the terms of the federal
583 Personal Responsibility and Work Opportunity Reconciliation Act of
584 1996 (Public Law 104-193), persons who become ineligible for
585 assistance under Title IV-A of the federal Social Security Act, as
586 amended, because of increased income from or hours of employment
587 of the caretaker relative or because of the expiration of the
588 applicable earned income disregards, who were eligible for
589 Medicaid for at least three (3) of the six (6) months preceding
590 the month in which the ineligibility begins, shall be eligible for

591 Medicaid for up to twelve (12) months. The eligibility of the
592 individuals covered under this paragraph shall be determined by
593 the division.
594 (18) Persons who become ineligible for assistance under
595 Title IV-A of the federal Social Security Act, as amended, as a
596 result, in whole or in part, of the collection or increased
597 collection of child or spousal support under Title IV-D of the
598 federal Social Security Act, as amended, who were eligible for
599 Medicaid for at least three (3) of the six (6) months immediately
600 preceding the month in which the ineligibility begins, shall be
601 eligible for Medicaid for an additional four (4) months beginning
602 with the month in which the ineligibility begins. The eligibility
603 of the individuals covered under this paragraph shall be
604 determined by the division.
605 (19) Disabled workers, whose incomes are above the
606 Medicaid eligibility limits, but below two hundred fifty percent
607 (250%) of the federal poverty level, shall be allowed to purchase
608 Medicaid coverage on a sliding fee scale developed by the Division
609 of Medicaid.
610 (20) Medicaid eligible children under age eighteen (18)
611 shall remain eligible for Medicaid benefits until the end of a
612 period of twelve (12) months following an eligibility
613 determination, or until such time that the individual exceeds age
614 eighteen (18).
615 (21) Women of childbearing age whose family income does
616 not exceed one hundred eighty-five percent (185%) of the federal
617 poverty level. The eligibility of individuals covered under this
618 paragraph (21) shall be determined by the Division of Medicaid,
619 and those individuals determined eligible shall only receive
620 family planning services covered under Section 43-13-117(13) and
621 not any other services covered under Medicaid. However, any
622 individual eligible under this paragraph (21) who is also eligible
623 under any other provision of this section shall receive the

624 benefits to which he or she is entitled under that other
625 provision, in addition to family planning services covered under
626 Section 43-13-117(13).

627 The Division of Medicaid shall apply to the United States
628 Secretary of Health and Human Services for a federal waiver of the
629 applicable provisions of Title XIX of the federal Social Security
630 Act, as amended, and any other applicable provisions of federal
631 law as necessary to allow for the implementation of this paragraph
632 (21). The provisions of this paragraph (21) shall be implemented
633 from and after the date that the Division of Medicaid receives the
634 federal waiver.

635 (22) Persons who are workers with a potentially severe
636 disability, as determined by the division, shall be allowed to
637 purchase Medicaid coverage. The term "worker with a potentially
638 severe disability" means a person who is at least sixteen (16)
639 years of age but under sixty-five (65) years of age, who has a
640 physical or mental impairment that is reasonably expected to cause
641 the person to become blind or disabled as defined under Section
642 1614(a) of the federal Social Security Act, as amended, if the
643 person does not receive items and services provided under
644 Medicaid.

645 The eligibility of persons under this paragraph (22) shall be
646 conducted as a demonstration project that is consistent with
647 Section 204 of the Ticket to Work and Work Incentives Improvement
648 Act of 1999, Public Law 106-170, for a certain number of persons
649 as specified by the division. The eligibility of individuals
650 covered under this paragraph (22) shall be determined by the
651 Division of Medicaid.

652 (23) Children certified by the Mississippi Department
653 of Human Services for whom the state and county departments of
654 human services have custody and financial responsibility who are
655 in foster care on their eighteenth birthday as reported by the
656 Mississippi Department of Human Services shall be certified

657 Medicaid eligible by the Division of Medicaid until their
658 twenty-first birthday.
659 (24) Individuals who have not attained age sixty-five
660 (65), are not otherwise covered by creditable coverage as defined
661 in the Public Health Services Act, and have been screened for
662 breast and cervical cancer under the Centers for Disease Control
663 and Prevention Breast and Cervical Cancer Early Detection Program
664 established under Title XV of the Public Health Service Act in
665 accordance with the requirements of that act and who need
666 treatment for breast or cervical cancer. Eligibility of
667 individuals under this paragraph (24) shall be determined by the
668 Division of Medicaid.
669 (25) The division shall apply to the Centers for
670 Medicare and Medicaid Services (CMS) for any necessary waivers to
671 provide services to individuals who are sixty-five (65) years of
672 age or older or are disabled as determined under Section
673 1614(a)(3) of the federal Social Security Act, as amended, and
674 whose income does not exceed one hundred thirty-five percent
675 (135%) of the nonfarm official poverty level as defined by the
676 Office of Management and Budget and revised annually, and whose
677 resources do not exceed those established by the Division of
678 Medicaid, and who are not otherwise covered by Medicare. Nothing
679 contained in this paragraph (25) shall entitle an individual to
680 benefits. The eligibility of individuals covered under this
681 paragraph shall be determined by the Division of Medicaid.
682 (26) The division shall apply to the Centers for
683 Medicare and Medicaid Services (CMS) for any necessary waivers to
684 provide services to individuals who are sixty-five (65) years of
685 age or older or are disabled as determined under Section
686 1614(a)(3) of the federal Social Security Act, as amended, who are
687 end stage renal disease patients on dialysis, cancer patients on
688 chemotherapy or organ transplant recipients on anti-rejection
689 drugs, whose income does not exceed one hundred thirty-five

690 percent (135%) of the nonfarm official poverty level as defined by
691 the Office of Management and Budget and revised annually, and
692 whose resources do not exceed those established by the division.
693 Nothing contained in this paragraph (26) shall entitle an
694 individual to benefits. The eligibility of individuals covered
695 under this paragraph shall be determined by the Division of
696 Medicaid.

697 (27) Individuals who are entitled to Medicare Part D
698 and whose income does not exceed one hundred fifty percent (150%)
699 of the nonfarm official poverty level as defined by the Office of
700 Management and Budget and revised annually. Eligibility for
701 payment of the Medicare Part D subsidy under this paragraph shall
702 be determined by the division.

703 The division shall redetermine eligibility for all categories
704 of recipients described in each paragraph of this section not less
705 frequently than required by federal law.

706 **SECTION 9.** Section 43-13-116, Mississippi Code of 1972, is
707 brought forward as follows:

708 43-13-116. (1) It shall be the duty of the Division of
709 Medicaid to fully implement and carry out the administrative
710 functions of determining the eligibility of those persons who
711 qualify for medical assistance under Section 43-13-115.

712 (2) In determining Medicaid eligibility, the Division of
713 Medicaid is authorized to enter into an agreement with the
714 Secretary of the Department of Health and Human Services for the
715 purpose of securing the transfer of eligibility information from
716 the Social Security Administration on those individuals receiving
717 supplemental security income benefits under the federal Social
718 Security Act and any other information necessary in determining
719 Medicaid eligibility. The Division of Medicaid is further
720 empowered to enter into contractual arrangements with its fiscal
721 agent or with the State Department of Human Services in securing
722 electronic data processing support as may be necessary.

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

736 (a) A request may be made either for a local regional
737 office hearing or a state office hearing when the local regional
738 office has made the initial decision that the claimant seeks to
739 appeal or when the regional office has not acted with reasonable
740 promptness in making a decision on a claim for eligibility or
741 services. The only exception to requesting a local hearing is
742 when the issue under appeal involves either (i) a disability or
743 blindness denial, or termination, or (ii) a level of care denial
744 or termination for a disabled child living at home. An appeal
745 involving disability, blindness or level of care must be handled
746 as a state level hearing. The decision from the local hearing may
747 be appealed to the state office for a state hearing. A decision
748 to deny, reduce or terminate benefits that is initially made at
749 the state office may be appealed by requesting a state hearing.

750 (b) A request for a hearing, either state or local,
751 must be made in writing by the claimant or claimant's legal
752 representative. "Legal representative" includes the claimant's
753 authorized representative, an attorney retained by the claimant or
754 claimant's family to represent the claimant, a paralegal
755 representative with a legal aid services, a parent of a minor

756 child if the claimant is a child, a legal guardian or conservator
757 or an individual with power of attorney for the claimant. The
758 claimant may also be represented by anyone that he or she so
759 designates but must give the designation to the Medicaid regional
760 office or state office in writing, if the person is not the legal
761 representative, legal guardian, or authorized representative.

762 (c) The claimant may make a request for a hearing in
763 person at the regional office but an oral request must be put into
764 written form. Regional office staff will determine from the
765 claimant if a local or state hearing is requested and assist the
766 claimant in completing and signing the appropriate form. Regional
767 office staff may forward a state hearing request to the
768 appropriate division in the state office or the claimant may mail
769 the form to the address listed on the form. The claimant may make
770 a written request for a hearing by letter. A simple statement
771 requesting a hearing that is signed by the claimant or legal
772 representative is sufficient; however, if possible, the claimant
773 should state the reason for the request. The letter may be mailed
774 to the regional office or it may be mailed to the state office. If
775 the letter does not specify the type of hearing desired, local or
776 state, Medicaid staff will attempt to contact the claimant to
777 determine the level of hearing desired. If contact cannot be made
778 within three (3) days of receipt of the request, the request will
779 be assumed to be for a local hearing and scheduled accordingly. A
780 hearing will not be scheduled until either a letter or the
781 appropriate form is received by the regional or state office.

782 (d) When both members of a couple wish to appeal an
783 action or inaction by the agency that affects both applications or
784 cases similarly and arose from the same issue, one or both may
785 file the request for hearing, both may present evidence at the
786 hearing, and the agency's decision will be applicable to both. If
787 both file a request for hearing, two (2) hearings will be
788 registered but they will be conducted on the same day and in the

789 same place, either consecutively or jointly, as the couple wishes.
790 If they so desire, only one of the couple need attend the hearing.
791 (e) The procedure for administrative hearings shall be
792 as follows:
793 (i) The claimant has thirty (30) days from the
794 date the agency mails the appropriate notice to the claimant of
795 its decision regarding eligibility, services, or benefits to
796 request either a state or local hearing. This time period may be
797 extended if the claimant can show good cause for not filing within
798 thirty (30) days. Good cause includes, but may not be limited to,
799 illness, failure to receive the notice, being out of state, or
800 some other reasonable explanation. If good cause can be shown, a
801 late request may be accepted provided the facts in the case remain
802 the same. If a claimant's circumstances have changed or if good
803 cause for filing a request beyond thirty (30) days is not shown, a
804 hearing request will not be accepted. If the claimant wishes to
805 have eligibility reconsidered, he or she may reapply.
806 (ii) If a claimant or representative requests a
807 hearing in writing during the advance notice period before
808 benefits are reduced or terminated, benefits must be continued or
809 reinstated to the benefit level in effect before the effective
810 date of the adverse action. Benefits will continue at the
811 original level until the final hearing decision is rendered. Any
812 hearing requested after the advance notice period will not be
813 accepted as a timely request in order for continuation of benefits
814 to apply.
815 (iii) Upon receipt of a written request for a
816 hearing, the request will be acknowledged in writing within twenty
817 (20) days and a hearing scheduled. The claimant or representative
818 will be given at least five (5) days' advance notice of the
819 hearing date. The local and/or state level hearings will be held
820 by telephone unless, at the hearing officer's discretion, it is
821 determined that an in-person hearing is necessary. If a local

822 hearing is requested, the regional office will notify the claimant
823 or representative in writing of the time of the local hearing. If
824 a state hearing is requested, the state office will notify the
825 claimant or representative in writing of the time of the state
826 hearing. If an in-person hearing is necessary, local hearings
827 will be held at the regional office and state hearings will be
828 held at the state office unless other arrangements are
829 necessitated by the claimant's inability to travel.

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

834 (v) A state or local hearing request may be
835 withdrawn at any time before the scheduled hearing, or after the
836 hearing is held but before a decision is rendered. The withdrawal
837 must be in writing and signed by the claimant or representative.
838 A hearing request will be considered abandoned if the claimant or
839 representative fails to appear at a scheduled hearing without good
840 cause. If no one appears for a hearing, the appropriate office
841 will notify the claimant in writing that the hearing is dismissed
842 unless good cause is shown for not attending. The proposed agency
843 action will be taken on the case following failure to appear for a
844 hearing if the action has not already been effected.

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

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

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

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

855 (D) The right to present an argument without
856 undue interference;
857 (E) The right to question or refute any
858 testimony or evidence including an opportunity to confront and
859 cross-examine adverse witnesses.
860 (vii) When a request for a local hearing is
861 received by the regional office or if the regional office is
862 notified by the state office that a local hearing has been
863 requested, the Medicaid specialist supervisor in the regional
864 office will review the case record, reexamine the action taken on
865 the case, and determine if policy and procedures have been
866 followed. If any adjustments or corrections should be made, the
867 Medicaid specialist supervisor will ensure that corrective action
868 is taken. If the request for hearing was timely made such that
869 continuation of benefits applies, the Medicaid specialist
870 supervisor will ensure that benefits continue at the level before
871 the proposed adverse action that is the subject of the appeal.
872 The Medicaid specialist supervisor will also ensure that all
873 needed information, verification, and evidence is in the case
874 record for the hearing.
875 (viii) When a state hearing is requested that
876 appeals the action or inaction of a regional office, the regional
877 office will prepare copies of the case record and forward it to
878 the appropriate division in the state office no later than five
879 (5) days after receipt of the request for a state hearing. The
880 original case record will remain in the regional office. Either
881 the original case record in the regional office or the copy
882 forwarded to the state office will be available for inspection by
883 the claimant or claimant's representative a reasonable time before
884 the date of the hearing.
885 (ix) The Medicaid specialist supervisor will serve
886 as the hearing officer for a local hearing unless the Medicaid
887 specialist supervisor actually participated in the eligibility,

888 benefits, or services decision under appeal, in which case the
889 Medicaid specialist supervisor must appoint a Medicaid specialist
890 in the regional office who did not actually participate in the
891 decision under appeal to serve as hearing officer. The local
892 hearing will be an informal proceeding in which the claimant or
893 representative may present new or additional information, may
894 question the action taken on the client's case, and will hear an
895 explanation from agency staff as to the regulations and
896 requirements that were applied to claimant's case in making the
897 decision.

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

913 (xi) The claimant has the right to appeal a local
914 hearing decision by requesting a state hearing in writing within
915 fifteen (15) days of the mailing date of the notice of local
916 hearing decision. The state hearing request should be made to the
917 regional office. If benefits have been continued pending the
918 local hearing process, then benefits will continue throughout the
919 fifteen-day advance notice period for an adverse local hearing
920 decision. If a state hearing is timely requested within the

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

932 (xii) When a request for a state hearing is
933 received in the regional office, the request will be made part of
934 the case record and the regional office will prepare the case
935 record and forward it to the appropriate division in the state
936 office within five (5) days of receipt of the state hearing
937 request. A request for a state hearing received in the state
938 office will be forwarded to the regional office for inclusion in
939 the case record and the regional office will prepare the case
940 record and forward it to the appropriate division in the state
941 office within five (5) days of receipt of the state hearing
942 request.

943 (xiii) Upon receipt of the hearing record, an
944 impartial hearing officer will be assigned to hear the case either
945 by the Executive Director of the Division of Medicaid or his or
946 her designee. Hearing officers will be individuals with
947 appropriate expertise employed by the division and who have not
948 been involved in any way with the action or decision on appeal in
949 the case. The hearing officer will review the case record and if
950 the review shows that an error was made in the action of the
951 agency or in the interpretation of policy, or that a change of
952 policy has been made, the hearing officer will discuss these
953 matters with the appropriate agency personnel and request that an

954 appropriate adjustment be made. Appropriate agency personnel will
955 discuss the matter with the claimant and if the claimant is
956 agreeable to the adjustment of the claim, then agency personnel
957 will request in writing dismissal of the hearing and the reason
958 therefor, to be placed in the case record. If the hearing is to
959 go forward, it shall be scheduled by the hearing officer in the
960 manner set forth in subparagraph (iii) of this paragraph (e).

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

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

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

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

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

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

976 (F) That the final hearing decision will be
977 rendered by the Executive Director of the Division of Medicaid on
978 the basis of facts presented at the hearing and the case record
979 and that the claimant will be notified by letter of the final
980 decision.

981 (xv) During the hearing, the claimant and/or
982 representative will be allowed an opportunity to make a full
983 statement concerning the appeal and will be assisted, if
984 necessary, in disclosing all information on which the claim is
985 based. All persons representing the claimant and those
986 representing the Division of Medicaid will have the opportunity to

987 state all facts pertinent to the appeal. The hearing officer may
988 recess or continue the hearing for a reasonable time should
989 additional information or facts be required or if some change in
990 the claimant's circumstances occurs during the hearing process
991 which impacts the appeal. When all information has been
992 presented, the hearing officer will close the hearing and stop the
993 recorder.

994 (xvi) Immediately following the hearing the
995 hearing tape will be transcribed and a copy of the transcription
996 forwarded to the regional office for filing in the case record.
997 As soon as possible, the hearing officer shall review the evidence
998 and record of the proceedings, testimony, exhibits, and other
999 supporting documents, prepare a written summary of the facts as
1000 the hearing officer finds them, and prepare a written
1001 recommendation of action to be taken by the agency, citing
1002 appropriate policy and regulations that govern the recommendation.
1003 The decision cannot be based on any material, oral or written, not
1004 available to the claimant before or during the hearing. The
1005 hearing officer's recommendation will become part of the case
1006 record which will be submitted to the Executive Director of the
1007 Division of Medicaid for further review and decision.

1008 (xvii) The Executive Director of the Division of
1009 Medicaid, upon review of the recommendation, proceedings and the
1010 record, may sustain the recommendation of the hearing officer,
1011 reject the same, or remand the matter to the hearing officer to
1012 take additional testimony and evidence, in which case, the hearing
1013 officer thereafter shall submit to the executive director a new
1014 recommendation. The executive director shall prepare a written
1015 decision summarizing the facts and identifying policies and
1016 regulations that support the decision, which shall be mailed to
1017 the claimant and the representative, with a copy to the regional
1018 office if appropriate, as soon as possible after submission of a
1019 recommendation by the hearing officer. The decision notice will

1020 specify any action to be taken by the agency, specify any revised
1021 eligibility dates or, if continuation of benefits applies, will
1022 notify the claimant of the new effective date of reduction or
1023 termination of benefits or services, which will be fifteen (15)
1024 days from the mailing date of the notice of decision. The
1025 decision rendered by the Executive Director of the Division of
1026 Medicaid is final and binding. The claimant is entitled to seek
1027 judicial review in a court of proper jurisdiction.
1028 (xviii) The Division of Medicaid must take final
1029 administrative action on a hearing, whether state or local, within
1030 ninety (90) days from the date of the initial request for a
1031 hearing.
1032 (xix) A group hearing may be held for a number of
1033 claimants under the following circumstances:
1034 (A) The Division of Medicaid may consolidate
1035 the cases and conduct a single group hearing when the only issue
1036 involved is one (1) of a single law or agency policy;
1037 (B) The claimants may request a group hearing
1038 when there is one (1) issue of agency policy common to all of
1039 them.
1040 In all group hearings, whether initiated by the Division of
1041 Medicaid or by the claimants, the policies governing fair hearings
1042 must be followed. Each claimant in a group hearing must be
1043 permitted to present his or her own case and be represented by his
1044 or her own representative, or to withdraw from the group hearing
1045 and have his or her appeal heard individually. As in individual
1046 hearings, the hearing will be conducted only on the issue being
1047 appealed, and each claimant will be expected to keep individual
1048 testimony within a reasonable time frame as a matter of
1049 consideration to the other claimants involved.
1050 (xx) Any specific matter necessitating an
1051 administrative hearing not otherwise provided under this article
1052 or agency policy shall be afforded under the hearing procedures as

1053 outlined above. If the specific time frames of such a unique
1054 matter relating to requesting, granting, and concluding of the
1055 hearing is contrary to the time frames as set out in the hearing
1056 procedures above, the specific time frames will govern over the
1057 time frames as set out within these procedures.

1058 (4) The Executive Director of the Division of Medicaid, with
1059 the approval of the Governor, shall be authorized to employ
1060 eligibility, technical, clerical and supportive staff as may be
1061 required in carrying out and fully implementing the determination
1062 of Medicaid eligibility, including conducting quality control
1063 reviews and the investigation of the improper receipt of medical
1064 assistance. Staffing needs will be set forth in the annual
1065 appropriation act for the division. Additional office space as
1066 needed in performing eligibility, quality control and
1067 investigative functions shall be obtained by the division.

1068 **SECTION 10.** Section 43-13-117, Mississippi Code of 1972, is
1069 brought forward as follows:

1070 43-13-117. Medicaid as authorized by this article shall
1071 include payment of part or all of the costs, at the discretion of
1072 the division, with approval of the Governor, of the following
1073 types of care and services rendered to eligible applicants who
1074 have been determined to be eligible for that care and services,
1075 within the limits of state appropriations and federal matching
1076 funds:

1077 (1) Inpatient hospital services.

1078 (a) The division shall allow thirty (30) days of
1079 inpatient hospital care annually for all Medicaid recipients.
1080 Precertification of inpatient days must be obtained as required by
1081 the division. The division may allow unlimited days in
1082 disproportionate hospitals as defined by the division for eligible
1083 infants and children under the age of six (6) years if certified
1084 as medically necessary as required by the division.

1085 (b) From and after July 1, 1994, the Executive
1086 Director of the Division of Medicaid shall amend the Mississippi
1087 Title XIX Inpatient Hospital Reimbursement Plan to remove the
1088 occupancy rate penalty from the calculation of the Medicaid
1089 Capital Cost Component utilized to determine total hospital costs
1090 allocated to the Medicaid program.

1091 (c) Hospitals will receive an additional payment
1092 for the implantable programmable baclofen drug pump used to treat
1093 spasticity that is implanted on an inpatient basis. The payment
1094 pursuant to written invoice will be in addition to the facility's
1095 per diem reimbursement and will represent a reduction of costs on
1096 the facility's annual cost report, and shall not exceed Ten
1097 Thousand Dollars ($10,000.00) per year per recipient.

1098 (2) Outpatient hospital services.

1099 (a) Emergency services. The division shall allow
1100 six (6) medically necessary emergency room visits per beneficiary
1101 per fiscal year.

1102 (b) Other outpatient hospital services. The
1103 division shall allow benefits for other medically necessary
1104 outpatient hospital services (such as chemotherapy, radiation,
1105 surgery and therapy). Where the same services are reimbursed as
1106 clinic services, the division may revise the rate or methodology
1107 of outpatient reimbursement to maintain consistency, efficiency,
1108 economy and quality of care.

1109 (3) Laboratory and x-ray services.

1110 (4) Nursing facility services.

1111 (a) The division shall make full payment to
1112 nursing facilities for each day, not exceeding fifty-two (52) days
1113 per year, that a patient is absent from the facility on home
1114 leave. Payment may be made for the following home leave days in
1115 addition to the fifty-two-day limitation: Christmas, the day
1116 before Christmas, the day after Christmas, Thanksgiving, the day
1117 before Thanksgiving and the day after Thanksgiving.

1118 (b) From and after July 1, 1997, the division
1119 shall implement the integrated case-mix payment and quality
1120 monitoring system, which includes the fair rental system for
1121 property costs and in which recapture of depreciation is
1122 eliminated. The division may reduce the payment for hospital
1123 leave and therapeutic home leave days to the lower of the case-mix
1124 category as computed for the resident on leave using the
1125 assessment being utilized for payment at that point in time, or a
1126 case-mix score of 1.000 for nursing facilities, and shall compute
1127 case-mix scores of residents so that only services provided at the
1128 nursing facility are considered in calculating a facility's per
1129 diem.
1130 (c) From and after July 1, 1997, all state-owned
1131 nursing facilities shall be reimbursed on a full reasonable cost
1132 basis.
1133 (d) When a facility of a category that does not
1134 require a certificate of need for construction and that could not
1135 be eligible for Medicaid reimbursement is constructed to nursing
1136 facility specifications for licensure and certification, and the
1137 facility is subsequently converted to a nursing facility under a
1138 certificate of need that authorizes conversion only and the
1139 applicant for the certificate of need was assessed an application
1140 review fee based on capital expenditures incurred in constructing
1141 the facility, the division shall allow reimbursement for capital
1142 expenditures necessary for construction of the facility that were
1143 incurred within the twenty-four (24) consecutive calendar months
1144 immediately preceding the date that the certificate of need
1145 authorizing the conversion was issued, to the same extent that
1146 reimbursement would be allowed for construction of a new nursing
1147 facility under a certificate of need that authorizes that
1148 construction. The reimbursement authorized in this subparagraph
1149 (d) may be made only to facilities the construction of which was
1150 completed after June 30, 1989. Before the division shall be

1151 authorized to make the reimbursement authorized in this
1152 subparagraph (d), the division first must have received approval
1153 from the Centers for Medicare and Medicaid Services (CMS) of the
1154 change in the state Medicaid plan providing for the reimbursement.
1155 (e) The division shall develop and implement, not
1156 later than January 1, 2001, a case-mix payment add-on determined
1157 by time studies and other valid statistical data that will
1158 reimburse a nursing facility for the additional cost of caring for
1159 a resident who has a diagnosis of Alzheimer's or other related
1160 dementia and exhibits symptoms that require special care. Any
1161 such case-mix add-on payment shall be supported by a determination
1162 of additional cost. The division shall also develop and implement
1163 as part of the fair rental reimbursement system for nursing
1164 facility beds, an Alzheimer's resident bed depreciation enhanced
1165 reimbursement system that will provide an incentive to encourage
1166 nursing facilities to convert or construct beds for residents with
1167 Alzheimer's or other related dementia.
1168 (f) The division shall develop and implement an
1169 assessment process for long-term care services. The division may
1170 provide the assessment and related functions directly or through
1171 contract with the area agencies on aging.
1172 The division shall apply for necessary federal waivers to
1173 assure that additional services providing alternatives to nursing
1174 facility care are made available to applicants for nursing
1175 facility care.
1176 (5) Periodic screening and diagnostic services for
1177 individuals under age twenty-one (21) years as are needed to
1178 identify physical and mental defects and to provide health care
1179 treatment and other measures designed to correct or ameliorate
1180 defects and physical and mental illness and conditions discovered
1181 by the screening services, regardless of whether these services
1182 are included in the state plan. The division may include in its
1183 periodic screening and diagnostic program those discretionary

1184 services authorized under the federal regulations adopted to
1185 implement Title XIX of the federal Social Security Act, as
1186 amended. The division, in obtaining physical therapy services,
1187 occupational therapy services, and services for individuals with
1188 speech, hearing and language disorders, may enter into a
1189 cooperative agreement with the State Department of Education for
1190 the provision of those services to handicapped students by public
1191 school districts using state funds that are provided from the
1192 appropriation to the Department of Education to obtain federal
1193 matching funds through the division. The division, in obtaining
1194 medical and psychological evaluations for children in the custody
1195 of the State Department of Human Services may enter into a
1196 cooperative agreement with the State Department of Human Services
1197 for the provision of those services using state funds that are
1198 provided from the appropriation to the Department of Human
1199 Services to obtain federal matching funds through the division.
1200 (6) Physician's services. The division shall allow
1201 twelve (12) physician visits annually. All fees for physicians'
1202 services that are covered only by Medicaid shall be reimbursed at
1203 ninety percent (90%) of the rate established on January 1, 1999,
1204 and as may be adjusted each July thereafter, under Medicare (Title
1205 XVIII of the federal Social Security Act, as amended). The
1206 division may develop and implement a different reimbursement model
1207 or schedule for physician's services provided by physicians based
1208 at an academic health care center and by physicians at rural
1209 health centers that are associated with an academic health care
1210 center.
1211 (7) (a) Home health services for eligible persons, not
1212 to exceed in cost the prevailing cost of nursing facility
1213 services, not to exceed twenty-five (25) visits per year. All
1214 home health visits must be precertified as required by the
1215 division.
1216 (b) [Repealed]

1217 (8) Emergency medical transportation services. On
1218 January 1, 1994, emergency medical transportation services shall
1219 be reimbursed at seventy percent (70%) of the rate established
1220 under Medicare (Title XVIII of the federal Social Security Act, as
1221 amended). "Emergency medical transportation services" shall mean,
1222 but shall not be limited to, the following services by a properly
1223 permitted ambulance operated by a properly licensed provider in
1224 accordance with the Emergency Medical Services Act of 1974
1225 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced
1226 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
1227 (vi) disposable supplies, (vii) similar services.
1228 (9) (a) Legend and other drugs as may be determined by
1229 the division.
1230 The division shall establish a mandatory preferred drug list.
1231 Drugs not on the mandatory preferred drug list shall be made
1232 available by utilizing prior authorization procedures established
1233 by the division.
1234 The division may seek to establish relationships with other
1235 states in order to lower acquisition costs of prescription drugs
1236 to include single source and innovator multiple source drugs or
1237 generic drugs. In addition, if allowed by federal law or
1238 regulation, the division may seek to establish relationships with
1239 and negotiate with other countries to facilitate the acquisition
1240 of prescription drugs to include single source and innovator
1241 multiple source drugs or generic drugs, if that will lower the
1242 acquisition costs of those prescription drugs.
1243 The division shall allow for a combination of prescriptions
1244 for single source and innovator multiple source drugs and generic
1245 drugs to meet the needs of the beneficiaries, not to exceed five
1246 (5) prescriptions per month for each noninstitutionalized Medicaid
1247 beneficiary, with not more than two (2) of those prescriptions
1248 being for single source or innovator multiple source drugs.

1249 The executive director may approve specific maintenance drugs
1250 for beneficiaries with certain medical conditions, which may be
1251 prescribed and dispensed in three-month supply increments.
1252 Drugs prescribed for a resident of a psychiatric residential
1253 treatment facility must be provided in true unit doses when
1254 available. The division may require that drugs not covered by
1255 Medicare Part D for a resident of a long-term care facility be
1256 provided in true unit doses when available. Those drugs that were
1257 originally billed to the division but are not used by a resident
1258 in any of those facilities shall be returned to the billing
1259 pharmacy for credit to the division, in accordance with the
1260 guidelines of the State Board of Pharmacy and any requirements of
1261 federal law and regulation. Drugs shall be dispensed to a
1262 recipient and only one (1) dispensing fee per month may be
1263 charged. The division shall develop a methodology for reimbursing
1264 for restocked drugs, which shall include a restock fee as
1265 determined by the division not exceeding Seven Dollars and
1266 Eighty-two Cents ($7.82).
1267 The voluntary preferred drug list shall be expanded to
1268 function in the interim in order to have a manageable prior
1269 authorization system, thereby minimizing disruption of service to
1270 beneficiaries.
1271 Except for those specific maintenance drugs approved by the
1272 executive director, the division shall not reimburse for any
1273 portion of a prescription that exceeds a thirty-one-day supply of
1274 the drug based on the daily dosage.
1275 The division shall develop and implement a program of payment
1276 for additional pharmacist services, with payment to be based on
1277 demonstrated savings, but in no case shall the total payment
1278 exceed twice the amount of the dispensing fee.
1279 All claims for drugs for dually eligible Medicare/Medicaid
1280 beneficiaries that are paid for by Medicare must be submitted to

1281 Medicare for payment before they may be processed by the
1282 division's online payment system.
1283 The division shall develop a pharmacy policy in which drugs
1284 in tamper-resistant packaging that are prescribed for a resident
1285 of a nursing facility but are not dispensed to the resident shall
1286 be returned to the pharmacy and not billed to Medicaid, in
1287 accordance with guidelines of the State Board of Pharmacy.
1288 The division shall develop and implement a method or methods
1289 by which the division will provide on a regular basis to Medicaid
1290 providers who are authorized to prescribe drugs, information about
1291 the costs to the Medicaid program of single source drugs and
1292 innovator multiple source drugs, and information about other drugs
1293 that may be prescribed as alternatives to those single source
1294 drugs and innovator multiple source drugs and the costs to the
1295 Medicaid program of those alternative drugs.
1296 Notwithstanding any law or regulation, information obtained
1297 or maintained by the division regarding the prescription drug
1298 program, including trade secrets and manufacturer or labeler
1299 pricing, is confidential and not subject to disclosure except to
1300 other state agencies.
1301 (b) Payment by the division for covered
1302 multisource drugs shall be limited to the lower of the upper
1303 limits established and published by the Centers for Medicare and
1304 Medicaid Services (CMS) plus a dispensing fee, or the estimated
1305 acquisition cost (EAC) as determined by the division, plus a
1306 dispensing fee, or the providers' usual and customary charge to
1307 the general public.
1308 Payment for other covered drugs, other than multisource drugs
1309 with CMS upper limits, shall not exceed the lower of the estimated
1310 acquisition cost as determined by the division, plus a dispensing
1311 fee or the providers' usual and customary charge to the general
1312 public.

1313 Payment for nonlegend or over-the-counter drugs covered by
1314 the division shall be reimbursed at the lower of the division's
1315 estimated shelf price or the providers' usual and customary charge
1316 to the general public.
1317 The dispensing fee for each new or refill prescription,
1318 including nonlegend or over-the-counter drugs covered by the
1319 division, shall be not less than Three Dollars and Ninety-one
1320 Cents ($3.91), as determined by the division.
1321 The division shall not reimburse for single source or
1322 innovator multiple source drugs if there are equally effective
1323 generic equivalents available and if the generic equivalents are
1324 the least expensive.
1325 It is the intent of the Legislature that the pharmacists
1326 providers be reimbursed for the reasonable costs of filling and
1327 dispensing prescriptions for Medicaid beneficiaries.
1328 (10) (a) Dental care that is an adjunct to treatment
1329 of an acute medical or surgical condition; services of oral
1330 surgeons and dentists in connection with surgery related to the
1331 jaw or any structure contiguous to the jaw or the reduction of any
1332 fracture of the jaw or any facial bone; and emergency dental
1333 extractions and treatment related thereto. On July 1, 2007, fees
1334 for dental care and surgery under authority of this paragraph (10)
1335 shall be reimbursed as provided in paragraph (b). It is the
1336 intent of the Legislature that this rate revision for dental
1337 services will be an incentive designed to increase the number of
1338 dentists who actively provide Medicaid services. This dental
1339 services rate revision shall be known as the "James Russell Dumas
1340 Medicaid Dental Incentive Program."
1341 The division shall annually determine the effect of this
1342 incentive by evaluating the number of dentists who are Medicaid
1343 providers, the number who and the degree to which they are
1344 actively billing Medicaid, the geographic trends of where dentists
1345 are offering what types of Medicaid services and other statistics

1346 pertinent to the goals of this legislative intent. This data
1347 shall be presented to the Chair of the Senate Public Health and
1348 Welfare Committee and the Chair of the House Medicaid Committee.
1349 (b) The Division of Medicaid shall establish a fee
1350 schedule, to be effective from and after July 1, 2007, for dental
1351 services. The schedule shall provide for a fee for each dental
1352 service that is equal to a percentile of normal and customary
1353 private provider fees, as defined by the Ingenix Customized Fee
1354 Analyzer Report, which percentile shall be determined by the
1355 division. The schedule shall be reviewed annually by the division
1356 and dental fees shall be adjusted to reflect the percentile
1357 determined by the division.
1358 (c) For fiscal year 2008, the amount of state
1359 funds appropriated for reimbursement for dental care and surgery
1360 shall be increased by ten percent (10%) of the amount of state
1361 fund expenditures for that purpose for fiscal year 2007. For each
1362 of fiscal years 2009 and 2010, the amount of state funds
1363 appropriated for reimbursement for dental care and surgery shall
1364 be increased by ten percent (10%) of the amount of state fund
1365 expenditures for that purpose for the preceding fiscal year.
1366 (d) The division shall establish an annual benefit
1367 limit of Two Thousand Five Hundred Dollars ($2,500.00) in dental
1368 expenditures per Medicaid-eligible recipient; however, a recipient
1369 may exceed the annual limit on dental expenditures provided in
1370 this paragraph with prior approval of the division.
1371 (e) The division shall include dental services as
1372 a necessary component of overall health services provided to
1373 children who are eligible for services.
1374 (f) This paragraph (10) shall stand repealed on
1375 July 1, 2010.
1376 (11) Eyeglasses for all Medicaid beneficiaries who have
1377 (a) had surgery on the eyeball or ocular muscle that results in a
1378 vision change for which eyeglasses or a change in eyeglasses is

1379 medically indicated within six (6) months of the surgery and is in
1380 accordance with policies established by the division, or (b) one
1381 (1) pair every five (5) years and in accordance with policies
1382 established by the division. In either instance, the eyeglasses
1383 must be prescribed by a physician skilled in diseases of the eye
1384 or an optometrist, whichever the beneficiary may select.
1385 (12) Intermediate care facility services.
1386 (a) The division shall make full payment to all
1387 intermediate care facilities for the mentally retarded for each
1388 day, not exceeding eighty-four (84) days per year, that a patient
1389 is absent from the facility on home leave. Payment may be made
1390 for the following home leave days in addition to the
1391 eighty-four-day limitation: Christmas, the day before Christmas,
1392 the day after Christmas, Thanksgiving, the day before Thanksgiving
1393 and the day after Thanksgiving.
1394 (b) All state-owned intermediate care facilities
1395 for the mentally retarded shall be reimbursed on a full reasonable
1396 cost basis.
1397 (13) Family planning services, including drugs,
1398 supplies and devices, when those services are under the
1399 supervision of a physician or nurse practitioner.
1400 (14) Clinic services. Such diagnostic, preventive,
1401 therapeutic, rehabilitative or palliative services furnished to an
1402 outpatient by or under the supervision of a physician or dentist
1403 in a facility that is not a part of a hospital but that is
1404 organized and operated to provide medical care to outpatients.
1405 Clinic services shall include any services reimbursed as
1406 outpatient hospital services that may be rendered in such a
1407 facility, including those that become so after July 1, 1991. On
1408 July 1, 1999, all fees for physicians' services reimbursed under
1409 authority of this paragraph (14) shall be reimbursed at ninety
1410 percent (90%) of the rate established on January 1, 1999, and as
1411 may be adjusted each July thereafter, under Medicare (Title XVIII

1412 of the federal Social Security Act, as amended). The division may
1413 develop and implement a different reimbursement model or schedule
1414 for physician's services provided by physicians based at an
1415 academic health care center and by physicians at rural health
1416 centers that are associated with an academic health care center.
1417 (15) Home- and community-based services for the elderly
1418 and disabled, as provided under Title XIX of the federal Social
1419 Security Act, as amended, under waivers, subject to the
1420 availability of funds specifically appropriated for that purpose
1421 by the Legislature.
1422 (16) Mental health services. Approved therapeutic and
1423 case management services (a) provided by an approved regional
1424 mental health/retardation center established under Sections
1425 41-19-31 through 41-19-39, or by another community mental health
1426 service provider meeting the requirements of the Department of
1427 Mental Health to be an approved mental health/retardation center
1428 if determined necessary by the Department of Mental Health, using
1429 state funds that are provided from the appropriation to the State
1430 Department of Mental Health and/or funds transferred to the
1431 department by a political subdivision or instrumentality of the
1432 state and used to match federal funds under a cooperative
1433 agreement between the division and the department, or (b) provided
1434 by a facility that is certified by the State Department of Mental
1435 Health to provide therapeutic and case management services, to be
1436 reimbursed on a fee for service basis, or (c) provided in the
1437 community by a facility or program operated by the Department of
1438 Mental Health. Any such services provided by a facility described
1439 in subparagraph (b) must have the prior approval of the division
1440 to be reimbursable under this section. After June 30, 1997,
1441 mental health services provided by regional mental
1442 health/retardation centers established under Sections 41-19-31
1443 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
1444 and/or their subsidiaries and divisions, or by psychiatric

1445 residential treatment facilities as defined in Section 43-11-1, or
1446 by another community mental health service provider meeting the
1447 requirements of the Department of Mental Health to be an approved
1448 mental health/retardation center if determined necessary by the
1449 Department of Mental Health, shall not be included in or provided
1450 under any capitated managed care pilot program provided for under
1451 paragraph (24) of this section.

1452 (17) Durable medical equipment services and medical
1453 supplies. Precertification of durable medical equipment and
1454 medical supplies must be obtained as required by the division.
1455 The Division of Medicaid may require durable medical equipment
1456 providers to obtain a surety bond in the amount and to the
1457 specifications as established by the Balanced Budget Act of 1997.

1458 (18) (a) Notwithstanding any other provision of this
1459 section to the contrary, the division shall make additional
1460 reimbursement to hospitals that serve a disproportionate share of
1461 low-income patients and that meet the federal requirements for
1462 those payments as provided in Section 1923 of the federal Social
1463 Security Act and any applicable regulations. It is the intent of
1464 the Legislature that the division shall draw down all available
1465 federal funds allotted to the state for disproportionate share
1466 hospitals. However, from and after January 1, 1999, no public
1467 hospital shall participate in the Medicaid disproportionate share
1468 program unless the public hospital participates in an
1469 intergovernmental transfer program as provided in Section 1903 of
1470 the federal Social Security Act and any applicable regulations.

1471 (b) The division shall establish a Medicare Upper
1472 Payment Limits Program, as defined in Section 1902(a)(30) of the
1473 federal Social Security Act and any applicable federal
1474 regulations, for hospitals, and may establish a Medicare Upper
1475 Payment Limits Program for nursing facilities. The division shall
1476 assess each hospital and, if the program is established for
1477 nursing facilities, shall assess each nursing facility, based on

1478 Medicaid utilization or other appropriate method consistent with
1479 federal regulations. The assessment will remain in effect as long
1480 as the state participates in the Medicare Upper Payment Limits
1481 Program. The division shall make additional reimbursement to
1482 hospitals and, if the program is established for nursing
1483 facilities, shall make additional reimbursement to nursing
1484 facilities, for the Medicare Upper Payment Limits, as defined in
1485 Section 1902(a)(30) of the federal Social Security Act and any
1486 applicable federal regulations.
1487 (19) (a) Perinatal risk management services. The
1488 division shall promulgate regulations to be effective from and
1489 after October 1, 1988, to establish a comprehensive perinatal
1490 system for risk assessment of all pregnant and infant Medicaid
1491 recipients and for management, education and follow-up for those
1492 who are determined to be at risk. Services to be performed
1493 include case management, nutrition assessment/counseling,
1494 psychosocial assessment/counseling and health education.
1495 (b) Early intervention system services. The
1496 division shall cooperate with the State Department of Health,
1497 acting as lead agency, in the development and implementation of a
1498 statewide system of delivery of early intervention services, under
1499 Part C of the Individuals with Disabilities Education Act (IDEA).
1500 The State Department of Health shall certify annually in writing
1501 to the executive director of the division the dollar amount of
1502 state early intervention funds available that will be utilized as
1503 a certified match for Medicaid matching funds. Those funds then
1504 shall be used to provide expanded targeted case management
1505 services for Medicaid eligible children with special needs who are
1506 eligible for the state's early intervention system.
1507 Qualifications for persons providing service coordination shall be
1508 determined by the State Department of Health and the Division of
1509 Medicaid.

1510 (20) Home- and community-based services for physically
1511 disabled approved services as allowed by a waiver from the United
1512 States Department of Health and Human Services for home- and
1513 community-based services for physically disabled people using
1514 state funds that are provided from the appropriation to the State
1515 Department of Rehabilitation Services and used to match federal
1516 funds under a cooperative agreement between the division and the
1517 department, provided that funds for these services are
1518 specifically appropriated to the Department of Rehabilitation
1519 Services.
1520 (21) Nurse practitioner services. Services furnished
1521 by a registered nurse who is licensed and certified by the
1522 Mississippi Board of Nursing as a nurse practitioner, including,
1523 but not limited to, nurse anesthetists, nurse midwives, family
1524 nurse practitioners, family planning nurse practitioners,
1525 pediatric nurse practitioners, obstetrics-gynecology nurse
1526 practitioners and neonatal nurse practitioners, under regulations
1527 adopted by the division. Reimbursement for those services shall
1528 not exceed ninety percent (90%) of the reimbursement rate for
1529 comparable services rendered by a physician.
1530 (22) Ambulatory services delivered in federally
1531 qualified health centers, rural health centers and clinics of the
1532 local health departments of the State Department of Health for
1533 individuals eligible for Medicaid under this article based on
1534 reasonable costs as determined by the division.
1535 (23) Inpatient psychiatric services. Inpatient
1536 psychiatric services to be determined by the division for
1537 recipients under age twenty-one (21) that are provided under the
1538 direction of a physician in an inpatient program in a licensed
1539 acute care psychiatric facility or in a licensed psychiatric
1540 residential treatment facility, before the recipient reaches age
1541 twenty-one (21) or, if the recipient was receiving the services
1542 immediately before he or she reached age twenty-one (21), before

1543 the earlier of the date he or she no longer requires the services
1544 or the date he or she reaches age twenty-two (22), as provided by
1545 federal regulations. Precertification of inpatient days and
1546 residential treatment days must be obtained as required by the
1547 division.

1548 (24) [Deleted]

1549 (25) [Deleted]

1550 (26) Hospice care. As used in this paragraph, the term
1551 "hospice care" means a coordinated program of active professional
1552 medical attention within the home and outpatient and inpatient
1553 care that treats the terminally ill patient and family as a unit,
1554 employing a medically directed interdisciplinary team. The
1555 program provides relief of severe pain or other physical symptoms
1556 and supportive care to meet the special needs arising out of
1557 physical, psychological, spiritual, social and economic stresses
1558 that are experienced during the final stages of illness and during
1559 dying and bereavement and meets the Medicare requirements for
1560 participation as a hospice as provided in federal regulations.

1561 (27) Group health plan premiums and cost sharing if it
1562 is cost effective as defined by the United States Secretary of
1563 Health and Human Services.

1564 (28) Other health insurance premiums that are cost
1565 effective as defined by the United States Secretary of Health and
1566 Human Services. Medicare eligible must have Medicare Part B
1567 before other insurance premiums can be paid.

1568 (29) The Division of Medicaid may apply for a waiver
1569 from the United States Department of Health and Human Services for
1570 home- and community-based services for developmentally disabled
1571 people using state funds that are provided from the appropriation
1572 to the State Department of Mental Health and/or funds transferred
1573 to the department by a political subdivision or instrumentality of
1574 the state and used to match federal funds under a cooperative
1575 agreement between the division and the department, provided that

1576 funds for these services are specifically appropriated to the
1577 Department of Mental Health and/or transferred to the department
1578 by a political subdivision or instrumentality of the state.
1579 (30) Pediatric skilled nursing services for eligible
1580 persons under twenty-one (21) years of age.
1581 (31) Targeted case management services for children
1582 with special needs, under waivers from the United States
1583 Department of Health and Human Services, using state funds that
1584 are provided from the appropriation to the Mississippi Department
1585 of Human Services and used to match federal funds under a
1586 cooperative agreement between the division and the department.
1587 (32) Care and services provided in Christian Science
1588 Sanatoria listed and certified by the Commission for Accreditation
1589 of Christian Science Nursing Organizations/Facilities, Inc.,
1590 rendered in connection with treatment by prayer or spiritual means
1591 to the extent that those services are subject to reimbursement
1592 under Section 1903 of the federal Social Security Act.
1593 (33) Podiatrist services.
1594 (34) Assisted living services as provided through home-
1595 and community-based services under Title XIX of the federal Social
1596 Security Act, as amended, subject to the availability of funds
1597 specifically appropriated for that purpose by the Legislature.
1598 (35) Services and activities authorized in Sections
1599 43-27-101 and 43-27-103, using state funds that are provided from
1600 the appropriation to the State Department of Human Services and
1601 used to match federal funds under a cooperative agreement between
1602 the division and the department.
1603 (36) Nonemergency transportation services for
1604 Medicaid-eligible persons, to be provided by the Division of
1605 Medicaid. The division may contract with additional entities to
1606 administer nonemergency transportation services as it deems
1607 necessary. All providers shall have a valid driver's license,
1608 vehicle inspection sticker, valid vehicle license tags and a

1609 standard liability insurance policy covering the vehicle. The
1610 division may pay providers a flat fee based on mileage tiers, or
1611 in the alternative, may reimburse on actual miles traveled. The
1612 division may apply to the Center for Medicare and Medicaid
1613 Services (CMS) for a waiver to draw federal matching funds for
1614 nonemergency transportation services as a covered service instead
1615 of an administrative cost. The PEER Committee shall conduct a
1616 performance evaluation of the nonemergency transportation program
1617 to evaluate the administration of the program and the providers of
1618 transportation services to determine the most cost effective ways
1619 of providing nonemergency transportation services to the patients
1620 served under the program. The performance evaluation shall be
1621 completed and provided to the members of the Senate Public Health
1622 and Welfare Committee and the House Medicaid Committee not later
1623 than January 15, 2008.
1624 (37) [Deleted]
1625 (38) Chiropractic services. A chiropractor's manual
1626 manipulation of the spine to correct a subluxation, if x-ray
1627 demonstrates that a subluxation exists and if the subluxation has
1628 resulted in a neuromusculoskeletal condition for which
1629 manipulation is appropriate treatment, and related spinal x-rays
1630 performed to document these conditions. Reimbursement for
1631 chiropractic services shall not exceed Seven Hundred Dollars
1632 ($700.00) per year per beneficiary.
1633 (39) Dually eligible Medicare/Medicaid beneficiaries.
1634 The division shall pay the Medicare deductible and coinsurance
1635 amounts for services available under Medicare, as determined by
1636 the division.
1637 (40) [Deleted]
1638 (41) Services provided by the State Department of
1639 Rehabilitation Services for the care and rehabilitation of persons
1640 with spinal cord injuries or traumatic brain injuries, as allowed
1641 under waivers from the United States Department of Health and

1642 Human Services, using up to seventy-five percent (75%) of the
1643 funds that are appropriated to the Department of Rehabilitation
1644 Services from the Spinal Cord and Head Injury Trust Fund
1645 established under Section 37-33-261 and used to match federal
1646 funds under a cooperative agreement between the division and the
1647 department.

1648 (42) Notwithstanding any other provision in this
1649 article to the contrary, the division may develop a population
1650 health management program for women and children health services
1651 through the age of one (1) year. This program is primarily for
1652 obstetrical care associated with low birth weight and pre-term
1653 babies. The division may apply to the federal Centers for
1654 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
1655 any other waivers that may enhance the program. In order to
1656 effect cost savings, the division may develop a revised payment
1657 methodology that may include at-risk capitated payments, and may
1658 require member participation in accordance with the terms and
1659 conditions of an approved federal waiver.

1660 (43) The division shall provide reimbursement,
1661 according to a payment schedule developed by the division, for
1662 smoking cessation medications for pregnant women during their
1663 pregnancy and other Medicaid-eligible women who are of
1664 child-bearing age.

1665 (44) Nursing facility services for the severely
1666 disabled.

1667 (a) Severe disabilities include, but are not
1668 limited to, spinal cord injuries, closed head injuries and
1669 ventilator dependent patients.

1670 (b) Those services must be provided in a long-term
1671 care nursing facility dedicated to the care and treatment of
1672 persons with severe disabilities, and shall be reimbursed as a
1673 separate category of nursing facilities.

1674 (45) Physician assistant services. Services furnished
1675 by a physician assistant who is licensed by the State Board of
1676 Medical Licensure and is practicing with physician supervision
1677 under regulations adopted by the board, under regulations adopted
1678 by the division. Reimbursement for those services shall not
1679 exceed ninety percent (90%) of the reimbursement rate for
1680 comparable services rendered by a physician.
1681 (46) The division shall make application to the federal
1682 Centers for Medicare and Medicaid Services (CMS) for a waiver to
1683 develop and provide services for children with serious emotional
1684 disturbances as defined in Section 43-14-1(1), which may include
1685 home- and community-based services, case management services or
1686 managed care services through mental health providers certified by
1687 the Department of Mental Health. The division may implement and
1688 provide services under this waivered program only if funds for
1689 these services are specifically appropriated for this purpose by
1690 the Legislature, or if funds are voluntarily provided by affected
1691 agencies.
1692 (47) (a) Notwithstanding any other provision in this
1693 article to the contrary, the division may develop and implement
1694 disease management programs for individuals with high-cost chronic
1695 diseases and conditions, including the use of grants, waivers,
1696 demonstrations or other projects as necessary.
1697 (b) Participation in any disease management
1698 program implemented under this paragraph (47) is optional with the
1699 individual. An individual must affirmatively elect to participate
1700 in the disease management program in order to participate, and
1701 may elect to discontinue participation in the program at any time.
1702 (48) Pediatric long-term acute care hospital services.
1703 (a) Pediatric long-term acute care hospital
1704 services means services provided to eligible persons under
1705 twenty-one (21) years of age by a freestanding Medicare-certified
1706 hospital that has an average length of inpatient stay greater than

1707 twenty-five (25) days and that is primarily engaged in providing
1708 chronic or long-term medical care to persons under twenty-one (21)
1709 years of age.

1710 (b) The services under this paragraph (48) shall
1711 be reimbursed as a separate category of hospital services.

1712 (49) The division shall establish copayments and/or
1713 coinsurance for all Medicaid services for which copayments and/or
1714 coinsurance are allowable under federal law or regulation, and
1715 shall set the amount of the copayment and/or coinsurance for each
1716 of those services at the maximum amount allowable under federal
1717 law or regulation.

1718 (50) Services provided by the State Department of
1719 Rehabilitation Services for the care and rehabilitation of persons
1720 who are deaf and blind, as allowed under waivers from the United
1721 States Department of Health and Human Services to provide home-
1722 and community-based services using state funds that are provided
1723 from the appropriation to the State Department of Rehabilitation
1724 Services or if funds are voluntarily provided by another agency.

1725 (51) Upon determination of Medicaid eligibility and in
1726 association with annual redetermination of Medicaid eligibility,
1727 beneficiaries shall be encouraged to undertake a physical
1728 examination that will establish a base-line level of health and
1729 identification of a usual and customary source of care (a medical
1730 home) to aid utilization of disease management tools. This
1731 physical examination and utilization of these disease management
1732 tools shall be consistent with current United States Preventive
1733 Services Task Force or other recognized authority recommendations.

1734 For persons who are determined ineligible for Medicaid, the
1735 division will provide information and direction for accessing
1736 medical care and services in the area of their residence.

1737 (52) Notwithstanding any provisions of this article,
1738 the division may pay enhanced reimbursement fees related to trauma
1739 care, as determined by the division in conjunction with the State

1740 Department of Health, using funds appropriated to the State
1741 Department of Health for trauma care and services and used to
1742 match federal funds under a cooperative agreement between the
1743 division and the State Department of Health. The division, in
1744 conjunction with the State Department of Health, may use grants,
1745 waivers, demonstrations, or other projects as necessary in the
1746 development and implementation of this reimbursement program.
1747 (53) Targeted case management services for high-cost
1748 beneficiaries shall be developed by the division for all services
1749 under this section.
1750 (54) Adult foster care services pilot program. Social
1751 and protective services on a pilot program basis in an approved
1752 foster care facility for vulnerable adults who would otherwise
1753 need care in a long-term care facility, to be implemented in an
1754 area of the state with the greatest need for such program, under
1755 the Medicaid Waivers for the Elderly and Disabled program or an
1756 assisted living waiver. The division may use grants, waivers,
1757 demonstrations or other projects as necessary in the development
1758 and implementation of this adult foster care services pilot
1759 program.
1760 (55) Therapy services. The plan of care for therapy
1761 services may be developed to cover a period of treatment for up to
1762 six (6) months, but in no event shall the plan of care exceed a
1763 six-month period of treatment. The projected period of treatment
1764 must be indicated on the initial plan of care and must be updated
1765 with each subsequent revised plan of care. Based on medical
1766 necessity, the division shall approve certification periods for
1767 less than or up to six (6) months, but in no event shall the
1768 certification period exceed the period of treatment indicated on
1769 the plan of care. The appeal process for any reduction in therapy
1770 services shall be consistent with the appeal process in federal
1771 regulations.

1772 Notwithstanding any other provision of this article to the
1773 contrary, the division shall reduce the rate of reimbursement to
1774 providers for any service provided under this section by five
1775 percent (5%) of the allowed amount for that service. However, the
1776 reduction in the reimbursement rates required by this paragraph
1777 shall not apply to inpatient hospital services, nursing facility
1778 services, intermediate care facility services, psychiatric
1779 residential treatment facility services, pharmacy services
1780 provided under paragraph (9) of this section, or any service
1781 provided by the University of Mississippi Medical Center or a
1782 state agency, a state facility or a public agency that either
1783 provides its own state match through intergovernmental transfer or
1784 certification of funds to the division, or a service for which the
1785 federal government sets the reimbursement methodology and rate.
1786 In addition, the reduction in the reimbursement rates required by
1787 this paragraph shall not apply to case management services and
1788 home-delivered meals provided under the home- and community-based
1789 services program for the elderly and disabled by a planning and
1790 development district (PDD). Planning and development districts
1791 participating in the home- and community-based services program
1792 for the elderly and disabled as case management providers shall be
1793 reimbursed for case management services at the maximum rate
1794 approved by the Centers for Medicare and Medicaid Services (CMS).
1795 The division may pay to those providers who participate in
1796 and accept patient referrals from the division's emergency room
1797 redirection program a percentage, as determined by the division,
1798 of savings achieved according to the performance measures and
1799 reduction of costs required of that program. Federally qualified
1800 health centers may participate in the emergency room redirection
1801 program, and the division may pay those centers a percentage of
1802 any savings to the Medicaid program achieved by the centers'
1803 accepting patient referrals through the program, as provided in
1804 this paragraph.

1805 Notwithstanding any provision of this article, except as
1806 authorized in the following paragraph and in Section 43-13-139,
1807 neither (a) the limitations on quantity or frequency of use of or
1808 the fees or charges for any of the care or services available to
1809 recipients under this section, nor (b) the payments or rates of
1810 reimbursement to providers rendering care or services authorized
1811 under this section to recipients, may be increased, decreased or
1812 otherwise changed from the levels in effect on July 1, 1999,
1813 unless they are authorized by an amendment to this section by the
1814 Legislature. However, the restriction in this paragraph shall not
1815 prevent the division from changing the payments or rates of
1816 reimbursement to providers without an amendment to this section
1817 whenever those changes are required by federal law or regulation,
1818 or whenever those changes are necessary to correct administrative
1819 errors or omissions in calculating those payments or rates of
1820 reimbursement.
1821 Notwithstanding any provision of this article, no new groups
1822 or categories of recipients and new types of care and services may
1823 be added without enabling legislation from the Mississippi
1824 Legislature, except that the division may authorize those changes
1825 without enabling legislation when the addition of recipients or
1826 services is ordered by a court of proper authority.
1827 The executive director shall keep the Governor advised on a
1828 timely basis of the funds available for expenditure and the
1829 projected expenditures. If current or projected expenditures of
1830 the division are reasonably anticipated to exceed the amount of
1831 funds appropriated to the division for any fiscal year, the
1832 Governor, after consultation with the executive director, shall
1833 discontinue any or all of the payment of the types of care and
1834 services as provided in this section that are deemed to be
1835 optional services under Title XIX of the federal Social Security
1836 Act, as amended, and when necessary, shall institute any other
1837 cost containment measures on any program or programs authorized

1838 under the article to the extent allowed under the federal law
1839 governing that program or programs. However, the Governor shall
1840 not be authorized to discontinue or eliminate any service under
1841 this section that is mandatory under federal law, or to
1842 discontinue or eliminate, or adjust income limits or resource
1843 limits for, any eligibility category or group under Section
1844 43-13-115. It is the intent of the Legislature that the
1845 expenditures of the division during any fiscal year shall not
1846 exceed the amounts appropriated to the division for that fiscal
1847 year.

1848 Notwithstanding any other provision of this article, it shall
1849 be the duty of each nursing facility, intermediate care facility
1850 for the mentally retarded, psychiatric residential treatment
1851 facility, and nursing facility for the severely disabled that is
1852 participating in the Medicaid program to keep and maintain books,
1853 documents and other records as prescribed by the Division of
1854 Medicaid in substantiation of its cost reports for a period of
1855 three (3) years after the date of submission to the Division of
1856 Medicaid of an original cost report, or three (3) years after the
1857 date of submission to the Division of Medicaid of an amended cost
1858 report.

1859 **SECTION 11.** Section 43-13-117.1, Mississippi Code of 1972,
1860 is brought forward as follows:

1861 43-13-117.1. It is the intent of the Legislature to expand
1862 access to Medicaid-funded home- and community-based services for
1863 eligible nursing facility residents who choose those services.
1864 The Executive Director of the Division of Medicaid is authorized
1865 to transfer funds allocated for nursing facility services for
1866 eligible residents to cover the cost of services available through
1867 the Independent Living Waiver, the Traumatic Brain Injury/Spinal
1868 Cord Injury Waiver, the Elderly and Disabled Waiver, and the
1869 Assisted Living Waiver programs when eligible residents choose
1870 those community services. The amount of funding transferred by

1871 the division shall be sufficient to cover the cost of home- and
1872 community-based waiver services for each eligible nursing facility
1873 residents who choose those services. The number of nursing
1874 facility residents who return to the community and home- and
1875 community-based waiver services shall not count against the total
1876 number of waiver slots for which the Legislature appropriates
1877 funding each year. Any funds remaining in the program when a
1878 former nursing facility resident ceases to participate in a home-
1879 and community-based waiver program under this provision shall be
1880 returned to nursing facility funding.
1881 **SECTION 12.** Section 43-13-117.2, Mississippi Code of 1972,
1882 is brought forward as follows:
1883 43-13-117.2. The Division of Medicaid is authorized and
1884 directed to study the feasibility of implementing a pilot program
1885 to provide chronic disease management of chronic obstructive
1886 pulmonary disease (COPD) using private sources of funding in an
1887 effort to reduce the financial and clinical burden of COPD illness
1888 upon the Medicaid program and the citizens of Mississippi. If a
1889 pilot program is deemed feasible, such a program shall be
1890 implemented and a report of findings and recommendations be
1891 prepared and provided to the Office of the Governor and the
1892 Chairmen of the House and Senate Public Health and Welfare
1893 Committees and the Chairman of the House Medicaid Committee in
1894 order to evaluate the effectiveness of the pilot program in
1895 reducing costs within the Medicaid program and in providing
1896 improved health and well-being of the affected patients.
1897 **SECTION 13.** Section 43-13-117.3, Mississippi Code of 1972,
1898 is brought forward as follows:
1899 43-13-117.3. The Division of Medicaid, in consultation with
1900 the State Department of Health and the State Department of
1901 Rehabilitation Services, is authorized and directed to study the
1902 feasibility of implementing a pilot program to provide bariatric
1903 surgery in the morbidly obese as a treatment option in an effort

1904 to reduce the financial and clinical burden of morbid obesity upon
1905 the Medicaid program and the citizens of Mississippi. If a pilot
1906 program is deemed feasible, that such a program be implemented and
1907 a report of findings and recommendations be prepared and provided
1908 to the Office of the Governor and the Chairmen of the House and
1909 Senate Public Health and Welfare Committees and the Chairman of
1910 the House Medicaid Committee in order to evaluate the
1911 effectiveness of the pilot program.

1912 **SECTION 14.** Section 43-13-118, Mississippi Code of 1972, is
1913 brought forward as follows:

1914 43-13-118. It shall be the duty of each provider
1915 participating in the medical assistance program to keep and
1916 maintain books, documents, and other records as prescribed by the
1917 division of Medicaid in substantiation of its claim for services
1918 rendered Medicaid recipients, and such books, documents, and other
1919 records shall be kept and maintained for a period of five (5)
1920 years or for whatever longer period as may be required or
1921 prescribed under federal or state statutes and shall be subject to
1922 audit by the division. The division shall be entitled to full
1923 recoupment of the amount it has paid any provider of medical
1924 service who has failed to keep or maintain records as required
1925 herein.

1926 **SECTION 15.** Section 43-13-120, Mississippi Code of 1972, is
1927 brought forward as follows:

1928 43-13-120. (1) Any person who is a Medicaid recipient and
1929 is receiving medical assistance for services provided in a
1930 long-term care facility under the provisions of Section 43-13-117
1931 from the Division of Medicaid in the Office of the Governor, who
1932 dies intestate and leaves no known heirs, shall have deemed,
1933 through his acceptance of such medical assistance, the Division of
1934 Medicaid as his beneficiary to all such funds in an amount not to
1935 exceed Two Hundred Fifty Dollars ($250.00) which are in his
1936 possession at the time of his death. Such funds, together with

1937 any accrued interest thereon, shall be reported by the long-term
1938 care facility to the State Treasurer in the manner provided in
1939 subsection (2).

1940 (2) The report of such funds shall be verified, shall be on
1941 a form prescribed or approved by the Treasurer, and shall include
1942 (a) the name of the deceased person and his last known address
1943 prior to entering the long-term care facility; (b) the name and
1944 last known address of each person who may possess an interest in
1945 such funds; and (c) any other information which the Treasurer
1946 prescribes by regulation as necessary for the administration of
1947 this section. The report shall be filed with the Treasurer prior
1948 to November 1 of each year in which the long-term care facility
1949 has provided services to a person or persons having funds to which
1950 this section applies.

1951 (3) Within one hundred twenty (120) days from November 1 of
1952 each year in which a report is made pursuant to subsection (2),
1953 the Treasurer shall cause notice to be published in a newspaper
1954 having general circulation in the county of this state in which is
1955 located the last known address of the person or persons named in
1956 the report who may possess an interest in such funds, or if no
1957 such person is named in the report, in the county in which is
1958 located the last known address of the deceased person prior to
1959 entering the long-term care facility. If no address is given in
1960 the report or if the address is outside of this state, the notice
1961 shall be published in a newspaper having general circulation in
1962 the county in which the facility is located. The notice shall
1963 contain (a) the name of the deceased person; (b) his last known
1964 address prior to entering the facility; (c) the name and last
1965 known address of each person named in the report who may possess
1966 an interest in such funds; and (d) a statement that any person
1967 possessing an interest in such funds must make a claim therefor to
1968 the Treasurer within ninety (90) days after such publication date
1969 or the funds will become the property of the State of Mississippi.

1970 In any year in which the Treasurer publishes a notice of abandoned
1971 property under Section 89-12-27, the Treasurer may combine the
1972 notice required by this section with the notice of abandoned
1973 property. The cost to the Treasurer of publishing the notice
1974 required by this section shall be paid by the Division of
1975 Medicaid.
1976 (4) Each long-term care facility that makes a report of
1977 funds of a deceased person under this section shall pay over and
1978 deliver such funds, together with any accrued interest thereon, to
1979 the Treasurer not later than ten (10) days after notice of such
1980 funds has been published by the Treasurer as provided in
1981 subsection (3). If a claim to such funds is not made by any
1982 person having an interest therein within ninety (90) days of the
1983 published notice, the Treasurer shall place such funds in the
1984 special account in the State Treasury to the credit of the
1985 "Governor's Office - Division of Medicaid" to be expended by the
1986 Division of Medicaid for the purposes provided under Mississippi
1987 Medicaid Law.
1988 (5) This section shall not be applicable to any Medicaid
1989 patient in a long-term care facility of a state institution listed
1990 in Section 41-7-73, who has a personal deposit fund as provided
1991 for in Section 41-7-90.
1992 **SECTION 16.** Section 43-13-121, Mississippi Code of 1972, is
1993 brought forward as follows:
1994 43-13-121. (1) The division shall administer the Medicaid
1995 program under the provisions of this article, and may do the
1996 following:
1997 (a) Adopt and promulgate reasonable rules, regulations
1998 and standards, with approval of the Governor, and in accordance
1999 with the Administrative Procedures Law, Section 25-43-1 et seq.:
2000 (i) Establishing methods and procedures as may be
2001 necessary for the proper and efficient administration of this
2002 article;

2003 (ii) Providing Medicaid to all qualified
2004 recipients under the provisions of this article as the division
2005 may determine and within the limits of appropriated funds;
2006 (iii) Establishing reasonable fees, charges and
2007 rates for medical services and drugs; in doing so, the division
2008 shall fix all of those fees, charges and rates at the minimum
2009 levels absolutely necessary to provide the medical assistance
2010 authorized by this article, and shall not change any of those
2011 fees, charges or rates except as may be authorized in Section
2012 43-13-117;
2013 (iv) Providing for fair and impartial hearings;
2014 (v) Providing safeguards for preserving the
2015 confidentiality of records; and
2016 (vi) For detecting and processing fraudulent
2017 practices and abuses of the program;
2018 (b) Receive and expend state, federal and other funds
2019 in accordance with court judgments or settlements and agreements
2020 between the State of Mississippi and the federal government, the
2021 rules and regulations promulgated by the division, with the
2022 approval of the Governor, and within the limitations and
2023 restrictions of this article and within the limits of funds
2024 available for that purpose;
2025 (c) Subject to the limits imposed by this article, to
2026 submit a Medicaid plan to the United States Department of Health
2027 and Human Services for approval under the provisions of the
2028 federal Social Security Act, to act for the state in making
2029 negotiations relative to the submission and approval of that plan,
2030 to make such arrangements, not inconsistent with the law, as may
2031 be required by or under federal law to obtain and retain that
2032 approval and to secure for the state the benefits of the
2033 provisions of that law.
2034 No agreements, specifically including the general plan for
2035 the operation of the Medicaid program in this state, shall be made

2036 by and between the division and the United States Department of
2037 Health and Human Services unless the Attorney General of the State
2038 of Mississippi has reviewed the agreements, specifically including
2039 the operational plan, and has certified in writing to the Governor
2040 and to the executive director of the division that the agreements,
2041 including the plan of operation, have been drawn strictly in
2042 accordance with the terms and requirements of this article;
2043 (d) In accordance with the purposes and intent of this
2044 article and in compliance with its provisions, provide for aged
2045 persons otherwise eligible for the benefits provided under Title
2046 XVIII of the federal Social Security Act by expenditure of funds
2047 available for those purposes;
2048 (e) To make reports to the United States Department of
2049 Health and Human Services as from time to time may be required by
2050 that federal department and to the Mississippi Legislature as
2051 provided in this section;
2052 (f) Define and determine the scope, duration and amount
2053 of Medicaid that may be provided in accordance with this article
2054 and establish priorities therefor in conformity with this article;
2055 (g) Cooperate and contract with other state agencies
2056 for the purpose of coordinating Medicaid provided under this
2057 article and eliminating duplication and inefficiency in the
2058 Medicaid program;
2059 (h) Adopt and use an official seal of the division;
2060 (i) Sue in its own name on behalf of the State of
2061 Mississippi and employ legal counsel on a contingency basis with
2062 the approval of the Attorney General;
2063 (j) To recover any and all payments incorrectly made by
2064 the division to a recipient or provider from the recipient or
2065 provider receiving the payments. To recover those payments, the
2066 division may use the following methods, in addition to any other
2067 methods available to the division:

2068 (i) The division shall report to the State Tax
2069 Commission the name of any current or former Medicaid recipient
2070 who has received medical services rendered during a period of
2071 established Medicaid ineligibility and who has not reimbursed the
2072 division for the related medical service payment(s). The State
2073 Tax Commission shall withhold from the state tax refund of the
2074 individual, and pay to the division, the amount of the payment(s)
2075 for medical services rendered to the ineligible individual that
2076 have not been reimbursed to the division for the related medical
2077 service payment(s).
2078 (ii) The division shall report to the State Tax
2079 Commission the name of any Medicaid provider to whom payments were
2080 incorrectly made that the division has not been able to recover by
2081 other methods available to the division. The State Tax Commission
2082 shall withhold from the state tax refund of the provider, and pay
2083 to the division, the amount of the payments that were incorrectly
2084 made to the provider that have not been recovered by other
2085 available methods;
2086 (k) To recover any and all payments by the division
2087 fraudulently obtained by a recipient or provider. Additionally,
2088 if recovery of any payments fraudulently obtained by a recipient
2089 or provider is made in any court, then, upon motion of the
2090 Governor, the judge of the court may award twice the payments
2091 recovered as damages;
2092 (l) Have full, complete and plenary power and authority
2093 to conduct such investigations as it may deem necessary and
2094 requisite of alleged or suspected violations or abuses of the
2095 provisions of this article or of the regulations adopted under
2096 this article, including, but not limited to, fraudulent or
2097 unlawful act or deed by applicants for Medicaid or other benefits,
2098 or payments made to any person, firm or corporation under the
2099 terms, conditions and authority of this article, to suspend or
2100 disqualify any provider of services, applicant or recipient for

2101 gross abuse, fraudulent or unlawful acts for such periods,
2102 including permanently, and under such conditions as the division
2103 deems proper and just, including the imposition of a legal rate of
2104 interest on the amount improperly or incorrectly paid. Recipients
2105 who are found to have misused or abused Medicaid benefits may be
2106 locked into one (1) physician and/or one (1) pharmacy of the
2107 recipient's choice for a reasonable amount of time in order to
2108 educate and promote appropriate use of medical services, in
2109 accordance with federal regulations. If an administrative hearing
2110 becomes necessary, the division may, if the provider does not
2111 succeed in his or her defense, tax the costs of the administrative
2112 hearing, including the costs of the court reporter or stenographer
2113 and transcript, to the provider. The convictions of a recipient
2114 or a provider in a state or federal court for abuse, fraudulent or
2115 unlawful acts under this chapter shall constitute an automatic
2116 disqualification of the recipient or automatic disqualification of
2117 the provider from participation under the Medicaid program.

2118 A conviction, for the purposes of this chapter, shall include
2119 a judgment entered on a plea of nolo contendere or a
2120 nonadjudicated guilty plea and shall have the same force as a
2121 judgment entered pursuant to a guilty plea or a conviction
2122 following trial. A certified copy of the judgment of the court of
2123 competent jurisdiction of the conviction shall constitute prima
2124 facie evidence of the conviction for disqualification purposes;

2125 (m) Establish and provide such methods of
2126 administration as may be necessary for the proper and efficient
2127 operation of the Medicaid program, fully utilizing computer
2128 equipment as may be necessary to oversee and control all current
2129 expenditures for purposes of this article, and to closely monitor
2130 and supervise all recipient payments and vendors rendering
2131 services under this article;

2132 (n) To cooperate and contract with the federal
2133 government for the purpose of providing Medicaid to Vietnamese and

2134 Cambodian refugees, under the provisions of Public Law 94-23 and
2135 Public Law 94-24, including any amendments to those laws, only to
2136 the extent that the Medicaid assistance and the administrative
2137 cost related thereto are one hundred percent (100%) reimbursable
2138 by the federal government. For the purposes of Section 43-13-117,
2139 persons receiving Medicaid under Public Law 94-23 and Public Law
2140 94-24, including any amendments to those laws, shall not be
2141 considered a new group or category of recipient; and

2142 (o) The division shall impose penalties upon Medicaid
2143 only, Title XIX participating long-term care facilities found to
2144 be in noncompliance with division and certification standards in
2145 accordance with federal and state regulations, including interest
2146 at the same rate calculated by the United States Department of
2147 Health and Human Services and/or the Centers for Medicare and
2148 Medicaid Services (CMS) under federal regulations.

2149 (2) The division also shall exercise such additional powers
2150 and perform such other duties as may be conferred upon the
2151 division by act of the Legislature.

2152 (3) The division, and the State Department of Health as the
2153 agency for licensure of health care facilities and certification
2154 and inspection for the Medicaid and/or Medicare programs, shall
2155 contract for or otherwise provide for the consolidation of on-site
2156 inspections of health care facilities that are necessitated by the
2157 respective programs and functions of the division and the
2158 department.

2159 (4) The division and its hearing officers shall have power
2160 to preserve and enforce order during hearings; to issue subpoenas
2161 for, to administer oaths to and to compel the attendance and
2162 testimony of witnesses, or the production of books, papers,
2163 documents and other evidence, or the taking of depositions before
2164 any designated individual competent to administer oaths; to
2165 examine witnesses; and to do all things conformable to law that
2166 may be necessary to enable them effectively to discharge the

2167 duties of their office. In compelling the attendance and
2168 testimony of witnesses, or the production of books, papers,
2169 documents and other evidence, or the taking of depositions, as
2170 authorized by this section, the division or its hearing officers
2171 may designate an individual employed by the division or some other
2172 suitable person to execute and return that process, whose action
2173 in executing and returning that process shall be as lawful as if
2174 done by the sheriff or some other proper officer authorized to
2175 execute and return process in the county where the witness may
2176 reside. In carrying out the investigatory powers under the
2177 provisions of this article, the executive director or other
2178 designated person or persons may examine, obtain, copy or
2179 reproduce the books, papers, documents, medical charts,
2180 prescriptions and other records relating to medical care and
2181 services furnished by the provider to a recipient or designated
2182 recipients of Medicaid services under investigation. In the
2183 absence of the voluntary submission of the books, papers,
2184 documents, medical charts, prescriptions and other records, the
2185 Governor, the executive director, or other designated person may
2186 issue and serve subpoenas instantly upon the provider, his or her
2187 agent, servant or employee for the production of the books,
2188 papers, documents, medical charts, prescriptions or other records
2189 during an audit or investigation of the provider. If any provider
2190 or his or her agent, servant or employee refuses to produce the
2191 records after being duly subpoenaed, the executive director may
2192 certify those facts and institute contempt proceedings in the
2193 manner, time and place as authorized by law for administrative
2194 proceedings. As an additional remedy, the division may recover
2195 all amounts paid to the provider covering the period of the audit
2196 or investigation, inclusive of a legal rate of interest and a
2197 reasonable attorney's fee and costs of court if suit becomes
2198 necessary. Division staff shall have immediate access to the
2199 provider's physical location, facilities, records, documents,

2200 books, and any other records relating to medical care and services
2201 rendered to recipients during regular business hours.
2202 (5) If any person in proceedings before the division
2203 disobeys or resists any lawful order or process, or misbehaves
2204 during a hearing or so near the place thereof as to obstruct the
2205 hearing, or neglects to produce, after having been ordered to do
2206 so, any pertinent book, paper or document, or refuses to appear
2207 after having been subpoenaed, or upon appearing refuses to take
2208 the oath as a witness, or after having taken the oath refuses to
2209 be examined according to law, the executive director shall certify
2210 the facts to any court having jurisdiction in the place in which
2211 it is sitting, and the court shall thereupon, in a summary manner,
2212 hear the evidence as to the acts complained of, and if the
2213 evidence so warrants, punish that person in the same manner and to
2214 the same extent as for a contempt committed before the court, or
2215 commit that person upon the same condition as if the doing of the
2216 forbidden act had occurred with reference to the process of, or in
2217 the presence of, the court.
2218 (6) In suspending or terminating any provider from
2219 participation in the Medicaid program, the division shall preclude
2220 the provider from submitting claims for payment, either personally
2221 or through any clinic, group, corporation or other association to
2222 the division or its fiscal agents for any services or supplies
2223 provided under the Medicaid program except for those services or
2224 supplies provided before the suspension or termination. No
2225 clinic, group, corporation or other association that is a provider
2226 of services shall submit claims for payment to the division or its
2227 fiscal agents for any services or supplies provided by a person
2228 within that organization who has been suspended or terminated from
2229 participation in the Medicaid program except for those services or
2230 supplies provided before the suspension or termination. When this
2231 provision is violated by a provider of services that is a clinic,
2232 group, corporation or other association, the division may suspend

2233 or terminate that organization from participation. Suspension may
2234 be applied by the division to all known affiliates of a provider,
2235 provided that each decision to include an affiliate is made on a
2236 case-by-case basis after giving due regard to all relevant facts
2237 and circumstances. The violation, failure or inadequacy of
2238 performance may be imputed to a person with whom the provider is
2239 affiliated where that conduct was accomplished within the course
2240 of his or her official duty or was effectuated by him or her with
2241 the knowledge or approval of that person.

2242 (7) The division may deny or revoke enrollment in the
2243 Medicaid program to a provider if any of the following are found
2244 to be applicable to the provider, his or her agent, a managing
2245 employee or any person having an ownership interest equal to five
2246 percent (5%) or greater in the provider:

2247 (a) Failure to truthfully or fully disclose any and all
2248 information required, or the concealment of any and all
2249 information required, on a claim, a provider application or a
2250 provider agreement, or the making of a false or misleading
2251 statement to the division relative to the Medicaid program.

2252 (b) Previous or current exclusion, suspension,
2253 termination from or the involuntary withdrawing from participation
2254 in the Medicaid program, any other state's Medicaid program,
2255 Medicare or any other public or private health or health insurance
2256 program. If the division ascertains that a provider has been
2257 convicted of a felony under federal or state law for an offense
2258 that the division determines is detrimental to the best interest
2259 of the program or of Medicaid beneficiaries, the division may
2260 refuse to enter into an agreement with that provider, or may
2261 terminate or refuse to renew an existing agreement.

2262 (c) Conviction under federal or state law of a criminal
2263 offense relating to the delivery of any goods, services or
2264 supplies, including the performance of management or
2265 administrative services relating to the delivery of the goods,

2266 services or supplies, under the Medicaid program, any other
2267 state's Medicaid program, Medicare or any other public or private
2268 health or health insurance program.

2269 (d) Conviction under federal or state law of a criminal
2270 offense relating to the neglect or abuse of a patient in
2271 connection with the delivery of any goods, services or supplies.

2272 (e) Conviction under federal or state law of a criminal
2273 offense relating to the unlawful manufacture, distribution,
2274 prescription or dispensing of a controlled substance.

2275 (f) Conviction under federal or state law of a criminal
2276 offense relating to fraud, theft, embezzlement, breach of
2277 fiduciary responsibility or other financial misconduct.

2278 (g) Conviction under federal or state law of a criminal
2279 offense punishable by imprisonment of a year or more that involves
2280 moral turpitude, or acts against the elderly, children or infirm.

2281 (h) Conviction under federal or state law of a criminal
2282 offense in connection with the interference or obstruction of any
2283 investigation into any criminal offense listed in paragraphs (c)
2284 through (i) of this subsection.

2285 (i) Sanction for a violation of federal or state laws
2286 or rules relative to the Medicaid program, any other state's
2287 Medicaid program, Medicare or any other public health care or
2288 health insurance program.

2289 (j) Revocation of license or certification.

2290 (k) Failure to pay recovery properly assessed or
2291 pursuant to an approved repayment schedule under the Medicaid
2292 program.

2293 (l) Failure to meet any condition of enrollment.

2294 **SECTION 17.** Section 43-13-122, Mississippi Code of 1972, is
2295 brought forward as follows:

2296 43-13-122. (1) The division is authorize to apply to the
2297 Center for Medicare and Medicaid Services of the United States

2298 Department of Health and Human Services for waivers and research
2299 and demonstration grants.
2300 (2) The division is further authorized to accept and expend
2301 any grants, donations or contributions from any public or private
2302 organization together with any additional federal matching funds
2303 that may accrue and including, but not limited to, one hundred
2304 percent (100%) federal grant funds or funds from any governmental
2305 entity or instrumentality thereof in furthering the purposes and
2306 objectives of the Mississippi Medicaid program, provided that such
2307 receipts and expenditures are reported and otherwise handled in
2308 accordance with the General Fund Stabilization Act. The
2309 Department of Finance and Administration is authorized to transfer
2310 monies to the division from special funds in the State Treasury in
2311 amounts not exceeding the amounts authorized in the appropriation
2312 to the division.
2313 **SECTION 18.** Section 43-13-123, Mississippi Code of 1972, is
2314 brought forward as follows:
2315 43-13-123. The determination of the method of providing
2316 payment of claims under this article shall be made by the
2317 division, with approval of the Governor, which methods may be:
2318 (a) By contract with insurance companies licensed to do
2319 business in the State of Mississippi or with nonprofit hospital
2320 service corporations, medical or dental service corporations,
2321 authorized to do business in Mississippi to underwrite on an
2322 insured premium approach, such medical assistance benefits as may
2323 be available, and any carrier selected under the provisions of
2324 this article is expressly authorized and empowered to undertake
2325 the performance of the requirements of that contract.
2326 (b) By contract with an insurance company licensed to
2327 do business in the State of Mississippi or with nonprofit hospital
2328 service, medical or dental service organizations, or other
2329 organizations including data processing companies, authorized to
2330 do business in Mississippi to act as fiscal agent.

2331 The division shall obtain services to be provided under
2332 either of the above-described provisions in accordance with the
2333 Personal Service Contract Review Board Procurement Regulations.
2334 The authorization of the foregoing methods shall not preclude
2335 other methods of providing payment of claims through direct
2336 operation of the program by the state or its agencies.
2337 **SECTION 19.** Section 43-13-125, Mississippi Code of 1972, is
2338 brought forward as follows:
2339 43-13-125. (1) If Medicaid is provided to a recipient under
2340 this article for injuries, disease or sickness caused under
2341 circumstances creating a cause of action in favor of the recipient
2342 against any person, firm or corporation, then the division shall
2343 be entitled to recover the proceeds that may result from the
2344 exercise of any rights of recovery that the recipient may have
2345 against any such person, firm or corporation to the extent of the
2346 Division of Medicaid's interest on behalf of the recipient. The
2347 recipient shall execute and deliver instruments and papers to do
2348 whatever is necessary to secure those rights and shall do nothing
2349 after Medicaid is provided to prejudice the subrogation rights of
2350 the division. Court orders or agreements for reimbursement of
2351 Medicaid's interest shall direct those payments to the Division of
2352 Medicaid, which shall be authorized to endorse any and all,
2353 including, but not limited to, multi-payee checks, drafts, money
2354 orders, or other negotiable instruments representing Medicaid
2355 payment recoveries that are received. In accordance with Section
2356 43-13-305, endorsement of multi-payee checks, drafts, money orders
2357 or other negotiable instruments by the Division of Medicaid shall
2358 be deemed endorsed by the recipient.
2359 The division, with the approval of the Governor, may
2360 compromise or settle any such claim and execute a release of any
2361 claim it has by virtue of this section.
2362 (2) The acceptance of Medicaid under this article or the
2363 making of a claim under this article shall not affect the right of

2364 a recipient or his or her legal representative to recover
2365 Medicaid's interest as an element of damages in any action at law;
2366 however, a copy of the pleadings shall be certified to the
2367 division at the time of the institution of suit, and proof of
2368 that notice shall be filed of record in that action. The division
2369 may, at any time before the trial on the facts, join in that
2370 action or may intervene in that action. Any amount recovered by a
2371 recipient or his or her legal representative shall be applied as
2372 follows:

2373 (a) The reasonable costs of the collection, including
2374 attorney's fees, as approved and allowed by the court in which
2375 that action is pending, or in case of settlement without suit, by
2376 the legal representative of the division;

2377 (b) The amount of Medicaid's interest on behalf of the
2378 recipient; or such pro rata amount as may be arrived at by the
2379 legal representative of the division and the recipient's attorney,
2380 or as set by the court having jurisdiction; and

2381 (c) Any excess shall be awarded to the recipient.

2382 (3) No compromise of any claim by the recipient or his or
2383 her legal representative shall be binding upon or affect the
2384 rights of the division against the third party unless the
2385 division, with the approval of the Governor, has entered into the
2386 compromise. Any compromise effected by the recipient or his or
2387 her legal representative with the third party in the absence of
2388 advance notification to and approved by the division shall
2389 constitute conclusive evidence of the liability of the third
2390 party, and the division, in litigating its claim against the third
2391 party, shall be required only to prove the amount and correctness
2392 of its claim relating to the injury, disease or sickness. If the
2393 recipient or his or her legal representative fails to notify the
2394 division of the institution of legal proceedings against a third
2395 party for which the division has a cause of action, the facts
2396 relating to negligence and the liability of the third party, if

2397 judgment is rendered for the recipient, shall constitute
2398 conclusive evidence of liability in a subsequent action maintained
2399 by the division and only the amount and correctness of the
2400 division's claim relating to injuries, disease or sickness shall
2401 be tried before the court. The division shall be authorized in
2402 bringing that action against the third party and his or her
2403 insurer jointly or against the insurer alone.
2404 (4) Nothing in this section shall be construed to diminish
2405 or otherwise restrict the subrogation rights of the Division of
2406 Medicaid against a third party for Medicaid provided by the
2407 Division of Medicaid to the recipient as a result of injuries,
2408 disease or sickness caused under circumstances creating a cause of
2409 action in favor of the recipient against such a third party.
2410 (5) Any amounts recovered by the division under this section
2411 shall, by the division, be placed to the credit of the funds
2412 appropriated for benefits under this article proportionate to the
2413 amounts provided by the state and federal governments
2414 respectively.
2415 **SECTION 20.** Section 43-13-126, Mississippi Code of 1972, is
2416 brought forward as follows:
2417 43-13-126. As a condition of doing business in the state,
2418 health insurers, including self-insured plans, group health plans
2419 (as defined in Section 607(1) of the Employee Retirement Income
2420 Security Act of 1974), service benefit plans, managed care
2421 organizations, pharmacy benefit managers, or other parties that
2422 are by statute, contract, or agreement, legally responsible for
2423 payment of a claim for a health care item or service, are required
2424 to:
2425 (a) Provide, with respect to individuals who are
2426 eligible for, or are provided, medical assistance under the state
2427 plan, upon the request of the Division of Medicaid, information to
2428 determine during what period the individual or their spouses or
2429 their dependents may be (or may have been) covered by a health

2430 insurer and the nature of the coverage that is or was provided by
2431 the health insurer (including the name, address and identifying
2432 number of the plan) in a manner prescribed by the Secretary of the
2433 Department of Health and Human Services;

2434 (b) Accept the Division of Medicaid's right of recovery
2435 and the assignment to the division of any right of an individual
2436 or other entity to payment from the party for an item or service
2437 for which payment has been made under the state plan;

2438 (c) Respond to any inquiry by the Division of Medicaid
2439 regarding a claim for payment for any health care item or service
2440 that is submitted not later than three (3) years after the date of
2441 the provision of that health care item or service; and

2442 (d) Agree not to deny a claim submitted by the Division
2443 of Medicaid solely on the basis of the date of submission of the
2444 claim, the type or format of the claim form, or a failure to
2445 present proper documentation at the point of sale that is the
2446 basis of the claim, if:

2447 (i) The claim is submitted by the division within
2448 the three-year period beginning on the date on which the item or
2449 service was furnished; and

2450 (ii) Any action by the division to enforce its
2451 rights with respect to the claim is begun within six (6) years of
2452 the division's submission of the claim.

2453 **SECTION 21.** Section 43-13-127, Mississippi Code of 1972, is
2454 brought forward as follows:

2455 43-13-127. (1) Within sixty (60) days after the end of each
2456 fiscal year and at each regular session of the Legislature, the
2457 division shall make and publish a report to the Governor and to
2458 the Legislature, showing for the period of time covered the
2459 following:

2460 (a) The total number of recipients;

2461 (b) The total amount paid for medical assistance and
2462 care under this article;

2463 (c) The total number of applications;
2464 (d) The number of applications approved;
2465 (e) The number of applications denied;
2466 (f) The amount expended for administration of the
2467 provisions of this article;
2468 (g) The amount of money received from the federal
2469 government, if any;
2470 (h) The amount of money recovered by reason of
2471 collections from third persons by reason of assignment or
2472 subrogation, and the disposition of the same;
2473 (i) The actions and activities of the division in
2474 detecting and investigating suspected or alleged fraudulent
2475 practices, violations and abuses of the program; and
2476 (j) Any recommendations it may have as to expanding,
2477 enlarging, limiting or restricting the eligibility of persons
2478 covered by this article or services provided by this article, to
2479 make more effective the basic purposes of this article; to
2480 eliminate or curtail fraudulent practices and inequities in the
2481 plan or administration thereof; and to continue to participate in
2482 receiving federal funds for the furnishing of medical assistance
2483 under Title XIX of the Social Security Act or other federal law.
2484 (2) In addition to the reports required by subsection (1) of
2485 this section, the division shall submit a report each month to the
2486 Chairmen of the Public Health and Welfare Committees of the Senate
2487 and the House of Representatives and to the Joint Legislative
2488 Budget Committee that contains the information specified in each
2489 paragraph of subsection (1) for the preceding month.
2490 **SECTION 22.** Section 43-13-129, Mississippi Code of 1972, is
2491 brought forward as follows:
2492 43-13-129. Any person making application for benefits under
2493 this article for himself or for another person, and any provider
2494 of services, who knowingly makes a false statement or false
2495 representation or fails to disclose a material fact to obtain or

2496 increase any benefit or payment under this article shall be guilty
2497 of a misdemeanor and, upon conviction thereof, shall be punished
2498 by a fine not to exceed Five Hundred Dollars ($500.00) or
2499 imprisoned not to exceed one (1) year, or by both such fine and
2500 imprisonment. Each false statement or false representation or
2501 failure to disclose a material fact shall constitute a separate
2502 offense. This section shall not prohibit prosecution under any
2503 other criminal statutes of this state or the United States.
2504 **SECTION 23.** Section 43-13-131, Mississippi Code of 1972, is
2505 brought forward as follows:
2506 43-13-131. Any person who shall, through intentional
2507 misrepresentation, fraud, deceit or unlawful design, either acting
2508 individually or in concert with others, influence any recipient to
2509 elect any particular provider of services, or any particular type
2510 of services, for the purposes and with the intent to obtain or
2511 increase any benefit or payment under this article shall be guilty
2512 of a misdemeanor and, upon conviction thereof, shall be punished
2513 by a fine not exceeding Five Hundred Dollars ($500.00) or
2514 imprisonment not exceeding one (1) year, or by both such fine and
2515 imprisonment. This section shall not prohibit prosecution under
2516 any other criminal statutes of this state or the United States.
2517 **SECTION 24.** Section 43-13-133, Mississippi Code of 1972, is
2518 brought forward as follows:
2519 43-13-133. It is the intent of the Legislature that all
2520 federal matching funds for medical assistance under Titles V,
2521 XVIII and XIX of the federal Social Security Act paid into any
2522 state health agency after the passage of this article shall be
2523 used exclusively to defray the cost of medical assistance expended
2524 under the terms of this article.
2525 **SECTION 25.** Section 43-13-137, Mississippi Code of 1972, is
2526 brought forward as follows:

2527 43-13-137. The division is an agency as defined under
2528 Section 25-43-3 and, therefore, must comply in all respects with
2529 the Administrative Procedures Law, Section 25-43-1 et seq.
2530 **SECTION 26.** Section 43-13-139, Mississippi Code of 1972, is
2531 brought forward as follows:
2532 43-13-139. Nothing contained in this article shall be
2533 construed to prevent the Governor, in his discretion, from
2534 discontinuing or limiting medical assistance to any individuals
2535 who are classified or deemed to be within any optional group or
2536 optional category of recipients as prescribed under Title XIX of
2537 the federal Social Security Act or the implementing federal
2538 regulations. If the Congress or the United States Department of
2539 Health and Human Services ceases to provide federal matching funds
2540 for any group or category of recipients or any type of care and
2541 services, the division shall cease state funding for such group or
2542 category or such type of care and services, notwithstanding any
2543 provision of this article.
2544 **SECTION 27.** Section 43-13-143, Mississippi Code of 1972, is
2545 brought forward as follows:
2546 43-13-143. There is created in the State Treasury a special
2547 fund to be known as the "Medical Care Fund," which shall be
2548 comprised of monies transferred by public or private health care
2549 providers, governing bodies of counties, municipalities, public or
2550 community hospitals and other political subdivisions of the state,
2551 individuals, corporations, associations and any other entities for
2552 the purpose of providing health care services. Any transfer made
2553 to the fund shall be paid to the State Treasurer for deposit into
2554 the fund, and all such transfers shall be considered as
2555 unconditional transfers to the fund. The monies in the Medical
2556 Care Fund shall be expended only for health care services, and may
2557 be expended only upon appropriation of the Legislature. All
2558 transfers of monies to the Division of Medicaid by health care
2559 providers and by governing bodies of counties, municipalities,

2560 public or community hospitals and other political subdivisions of
2561 the state shall be deposited into the fund. Unexpended monies
2562 remaining in the fund at the end of a fiscal year shall not lapse
2563 into the State General Fund, and any interest earned on monies in
2564 the fund shall be deposited to the credit of the fund.

2565 **SECTION 28.** Section 43-13-145, Mississippi Code of 1972, is
2566 brought forward as follows:

2567 43-13-145. (1) (a) Upon each nursing facility licensed by
2568 the State of Mississippi, there is levied an assessment in an
2569 amount set by the division, not exceeding the maximum rate allowed
2570 by federal law or regulation, for each licensed and occupied bed
2571 of the facility.

2572 (b) A nursing facility is exempt from the assessment
2573 levied under this subsection if the facility is operated under the
2574 direction and control of:

2575 (i) The United States Veterans Administration or
2576 other agency or department of the United States government;

2577 (ii) The State Veterans Affairs Board;

2578 (iii) The University of Mississippi Medical
2579 Center; or

2580 (iv) A state agency or a state facility that
2581 either provides its own state match through intergovernmental
2582 transfer or certification of funds to the division.

2583 (2) (a) Upon each intermediate care facility for the
2584 mentally retarded licensed by the State of Mississippi, there is
2585 levied an assessment in an amount set by the division, not
2586 exceeding the maximum rate allowed by federal law or regulation,
2587 for each licensed and occupied bed of the facility.

2588 (b) An intermediate care facility for the mentally
2589 retarded is exempt from the assessment levied under this
2590 subsection if the facility is operated under the direction and
2591 control of:

2592 (i) The United States Veterans Administration or
2593 other agency or department of the United States government;
2594 (ii) The State Veterans Affairs Board; or
2595 (iii) The University of Mississippi Medical
2596 Center.
2597 (3) (a) Upon each psychiatric residential treatment
2598 facility licensed by the State of Mississippi, there is levied an
2599 assessment in an amount set by the division, not exceeding the
2600 maximum rate allowed by federal law or regulation, for each
2601 licensed and occupied bed of the facility.
2602 (b) A psychiatric residential treatment facility is
2603 exempt from the assessment levied under this subsection if the
2604 facility is operated under the direction and control of:
2605 (i) The United States Veterans Administration or
2606 other agency or department of the United States government;
2607 (ii) The University of Mississippi Medical Center;
2608 (iii) A state agency or a state facility that
2609 either provides its own state match through intergovernmental
2610 transfer or certification of funds to the division.
2611 (4) (a) Upon each hospital licensed by the State of
2612 Mississippi, there is levied an assessment in the amount of Three
2613 Dollars and Twenty-five Cents ($3.25) per bed for each licensed
2614 inpatient acute care bed of the hospital.
2615 (b) A hospital is exempt from the assessment levied
2616 under this subsection if the hospital is operated under the
2617 direction and control of:
2618 (i) The United States Veterans Administration or
2619 other agency or department of the United States government;
2620 (ii) The University of Mississippi Medical Center;
2621 or
2622 (iii) A state agency or a state facility that
2623 either provides its own state match through intergovernmental
2624 transfer or certification of funds to the division.

2625 (5) Each health care facility that is subject to the
2626 provisions of this section shall keep and preserve such suitable
2627 books and records as may be necessary to determine the amount of
2628 assessment for which it is liable under this section. The books
2629 and records shall be kept and preserved for a period of not less
2630 than five (5) years, and those books and records shall be open for
2631 examination during business hours by the division, the State Tax
2632 Commission, the Office of the Attorney General and the State
2633 Department of Health.
2634 (6) The assessment levied under this section shall be
2635 collected by the division each month beginning on March 31, 2005.
2636 (7) All assessments collected under this section shall be
2637 deposited in the Medical Care Fund created by Section 43-13-143.
2638 (8) The assessment levied under this section shall be in
2639 addition to any other assessments, taxes or fees levied by law,
2640 and the assessment shall constitute a debt due the State of
2641 Mississippi from the time the assessment is due until it is paid.
2642 (9) (a) If a health care facility that is liable for
2643 payment of an assessment levied by the division does not pay the
2644 assessment when it is due, the division shall give written notice
2645 to the health care facility by certified or registered mail
2646 demanding payment of the assessment within ten (10) days from the
2647 date of delivery of the notice. If the health care facility
2648 fails or refuses to pay the assessment after receiving the notice
2649 and demand from the division, the division shall withhold from any
2650 Medicaid reimbursement payments that are due to the health care
2651 facility the amount of the unpaid assessment and a penalty of ten
2652 percent (10%) of the amount of the assessment, plus the legal rate
2653 of interest until the assessment is paid in full. If the health
2654 care facility does not participate in the Medicaid program, the
2655 division shall turn over to the Office of the Attorney General the
2656 collection of the unpaid assessment by civil action. In any such
2657 civil action, the Office of the Attorney General shall collect the

2658 amount of the unpaid assessment and a penalty of ten percent (10%)
2659 of the amount of the assessment, plus the legal rate of interest
2660 until the assessment is paid in full.

2661 (b) As an additional or alternative method for
2662 collecting unpaid assessments levied by the division, if a health
2663 care facility fails or refuses to pay the assessment after
2664 receiving notice and demand from the division, the division may
2665 file a notice of a tax lien with the circuit clerk of the county
2666 in which the health care facility is located, for the amount of
2667 the unpaid assessment and a penalty of ten percent (10%) of the
2668 amount of the assessment, plus the legal rate of interest until
2669 the assessment is paid in full. Immediately upon receipt of
2670 notice of the tax lien for the assessment, the circuit clerk shall
2671 enter the notice of the tax lien as a judgment upon the judgment
2672 roll and show in the appropriate columns the name of the health
2673 care facility as judgment debtor, the name of the division as
2674 judgment creditor, the amount of the unpaid assessment, and the
2675 date and time of enrollment. The judgment shall be valid as
2676 against mortgagees, pledgees, entrusters, purchasers, judgment
2677 creditors and other persons from the time of filing with the
2678 clerk. The amount of the judgment shall be a debt due the State
2679 of Mississippi and remain a lien upon the tangible property of the
2680 health care facility until the judgment is satisfied. The
2681 judgment shall be the equivalent of any enrolled judgment of a
2682 court of record and shall serve as authority for the issuance of
2683 writs of execution, writs of attachment or other remedial writs.

2684 **SECTION 29.** Section 27-69-13, Mississippi Code of 1972, is
2685 amended as follows:

2686 27-69-13. (1) There is *** * *** imposed, levied and assessed,
2687 to be collected and paid as *** * *** provided in this chapter, an
2688 excise tax on each person or dealer in cigarettes, cigars,
2689 stogies, snuff, chewing tobacco, and smoking tobacco, or

2690 substitutes therefor, upon the sale, use, consumption, handling or
2691 distribution in the State of Mississippi, as follows:
2692 (a) On cigarettes, the rate of tax shall be
2693 Eighteen-twentieths of One Cent (18/20 of 1¢) on each cigarette
2694 sold with a maximum length of one hundred twenty (120)
2695 millimeters; any cigarette in excess of this length shall be taxed
2696 as if it were two (2) or more cigarettes. * * * However, if the
2697 federal tax rate on cigarettes in effect on June 1, 1985, is
2698 reduced, then the rate as provided in this subsection shall be
2699 increased by the amount of the federal tax reduction. That tax
2700 increase shall take effect on the first day of the month following
2701 the effective date of the reduction in the federal tax rate.
2702 (b) In addition to the excise tax levied by paragraph
2703 (a), there is levied an excise tax of Two and One-half Cents
2704 (2-1/2¢) on each cigarette sold with a maximum length of one
2705 hundred twenty (120) millimeters; any cigarette in excess of this
2706 length shall be taxed as if it were two (2) or more cigarettes.
2707 (c) On cigars, cheroots, stogies, snuff, chewing and
2708 smoking tobacco and all other tobacco products except cigarettes,
2709 the rate of tax shall be fifteen percent (15%) of the
2710 manufacturer's list price.
2711 (2) No stamp evidencing the tax * * * levied in this section
2712 on cigarettes shall be of a denomination of less than One Cent
2713 (1¢), and whenever the tax computed at the rates * * * prescribed
2714 in this section on cigarettes is a specified amount, plus a
2715 fractional part of One Cent (1¢), the package shall be stamped for
2716 the next full cent; however, the additional face value of stamps
2717 purchased to comply with taxes imposed by this section after June
2718 1, 1985, shall be subject to a four percent (4%) discount or
2719 compensation to dealers for their services rather than the eight
2720 percent (8%) discount or compensation allowed by Section 27-69-31.

2721 (3) Every wholesaler shall purchase stamps as provided in
2722 this chapter, and affix the same to all packages of cigarettes
2723 handled by him as *** * *** provided in this chapter.
2724 (4) The above tax is levied upon the sale, use, gift,
2725 possession or consumption of tobacco within the State of
2726 Mississippi, and the impact of the tax levied by this chapter
2727 is *** * *** declared to be on the vendee, user, consumer or possessor
2728 of tobacco in this state; and when the tax is paid by any other
2729 person, the payment shall be considered as an advance payment and
2730 shall thereafter be added to the price of the tobacco and
2731 recovered from the ultimate consumer or user.
2732 **SECTION 30.** Section 27-69-75, Mississippi Code of 1972, is
2733 amended as follows:
2734 27-69-75. (1) All taxes levied by this chapter shall be
2735 payable to the commissioner in cash, or by personal check,
2736 cashier's check, bank exchange, post office money order or express
2737 money order, and shall be deposited by the commissioner in the
2738 State Treasury on the same day collected. No remittance other
2739 than cash shall be a final discharge of liability for the
2740 tax *** * *** assessed and levied in this chapter, unless and until it
2741 has been paid in cash to the commissioner.
2742 (2) The revenue derived from the tax levied in Section
2743 27-69-13(1)(b) shall be deposited into the State Treasury, as
2744 follows:
2745 (a) One third (1/3) of the revenue collected shall be
2746 deposited into the Health Care Expendable Fund created in Section
2747 43-13-407.
2748 (b) One third (1/3) of the revenue collected shall be
2749 deposited into the special fund to the credit of the University of
2750 Mississippi Medical Center that is created in Section 31 of this
2751 act.

2752 (c) One third (1/3) of the revenue collected shall be
2753 deposited into the Mississippi Trauma Care Systems Fund created in
2754 Section 41-59-75.
2755 (3) Except as otherwise provided in subsection (2) of this
2756 section, all tobacco taxes collected, including tobacco license
2757 taxes, shall be deposited into the State Treasury to the credit of
2758 the General Fund.
2759 Wholesalers who are entitled to purchase stamps at a
2760 discount, as provided by Section 27-69-31, may have consigned to
2761 them, without advance payment, those stamps, if and when the
2762 wholesaler * * * gives to the commissioner a good and sufficient
2763 bond executed by some surety company authorized to do business in
2764 this state, conditioned to secure the payment for the stamps so
2765 consigned. The commissioner shall require payment for the stamps
2766 not later than thirty (30) days from the date the stamps were
2767 consigned.
2768 **SECTION 31.** There is created in the State Treasury a special
2769 fund to the credit of the University of Mississippi Medical
2770 Center, which shall be comprised of the monies required to be
2771 deposited into the fund under Section 27-69-75(2)(b), and any
2772 other funds that may be made available for the fund by the
2773 Legislature. Monies in the fund shall be expended by the
2774 University of Mississippi Medical Center, upon appropriation by
2775 the Legislature, to pay the costs of medical services provided by
2776 the center for which it does not receive compensation or
2777 reimbursement from any other source. Unexpended amounts remaining
2778 in the special fund at the end of a fiscal year shall not lapse
2779 into the State General Fund, and any interest earned or investment
2780 earnings on amounts in the special fund shall be deposited to the
2781 credit of the special fund.
2782 **SECTION 32.** This act shall take effect and be in force from
2783 and after July 1, 2008.