MISSISSIPPI LEGISLATURE REGULAR SESSION 2024

By: Senator(s) Hill To: Medicaid

SENATE BILL NO. 2533

1 AN ACT TO AMEND SECTION 43-13-116, MISSISSIPPI CODE OF 1972,
2 TO PROVIDE THAT IN DETERMINING MEDICAID ELIGIBILITY, THE DIVISION
3 OF MEDICAID SHALL VERIFY ELIGIBILITY FOR ASSISTANCE BEFORE
4 AWARDING ASSISTANCE AND SHALL NOT RELY ON POTENTIAL BENEFICIARY'S
5 SELF-ATTESTATION OF RESIDENCY, HOUSEHOLD INCOME, ASSETS OR OTHER
6 RELEVANT FACTORS; AND FOR RELATED PURPOSES.

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

8 **SECTION 1.** Section 43-13-116, Mississippi Code of 1972, is
9 amended as follows:

10 43-13-116. (1) It shall be the duty of the Division of
11 Medicaid to fully implement and carry out the administrative
12 functions of determining the eligibility of those persons who
13 qualify for medical assistance under Section 43-13-115.

14 (2) In determining Medicaid eligibility, the Division of
15 Medicaid is authorized to enter into an agreement with the
16 Secretary of the Department of Health and Human Services for the
17 purpose of securing the transfer of eligibility information from
18 the Social Security Administration on those individuals receiving
19 supplemental security income benefits under the federal Social
20 Security Act and any other information necessary in determining

21 Medicaid eligibility. The Division of Medicaid is further
22 empowered to enter into contractual arrangements with its fiscal
23 agent or with the State Department of Human Services in securing
24 electronic data processing support as may be necessary.

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

38 (a) A request may be made either for a local regional
39 office hearing or a state office hearing when the local regional
40 office has made the initial decision that the claimant seeks to
41 appeal or when the regional office has not acted with reasonable
42 promptness in making a decision on a claim for eligibility or
43 services. The only exception to requesting a local hearing is
44 when the issue under appeal involves either (i) a disability or
45 blindness denial, or termination, or (ii) a level of care denial

46 or termination for a disabled child living at home. An appeal
47 involving disability, blindness or level of care must be handled
48 as a state level hearing. The decision from the local hearing may
49 be appealed to the state office for a state hearing. A decision
50 to deny, reduce or terminate benefits that is initially made at
51 the state office may be appealed by requesting a state hearing.

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

64 (c) The claimant may make a request for a hearing in
65 person at the regional office but an oral request must be put into
66 written form. Regional office staff will determine from the
67 claimant if a local or state hearing is requested and assist the
68 claimant in completing and signing the appropriate form. Regional
69 office staff may forward a state hearing request to the
70 appropriate division in the state office or the claimant may mail

71 the form to the address listed on the form. The claimant may make
72 a written request for a hearing by letter. A simple statement
73 requesting a hearing that is signed by the claimant or legal
74 representative is sufficient; however, if possible, the claimant
75 should state the reason for the request. The letter may be mailed
76 to the regional office or it may be mailed to the state office. If
77 the letter does not specify the type of hearing desired, local or
78 state, Medicaid staff will attempt to contact the claimant to
79 determine the level of hearing desired. If contact cannot be made
80 within three (3) days of receipt of the request, the request will
81 be assumed to be for a local hearing and scheduled accordingly. A
82 hearing will not be scheduled until either a letter or the
83 appropriate form is received by the regional or state office.

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

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

95 (i) The claimant has thirty (30) days from the
96 date the agency mails the appropriate notice to the claimant of
97 its decision regarding eligibility, services, or benefits to
98 request either a state or local hearing. This time period may be
99 extended if the claimant can show good cause for not filing within
100 thirty (30) days. Good cause includes, but may not be limited to,
101 illness, failure to receive the notice, being out of state, or
102 some other reasonable explanation. If good cause can be shown, a
103 late request may be accepted provided the facts in the case remain
104 the same. If a claimant's circumstances have changed or if good
105 cause for filing a request beyond thirty (30) days is not shown, a
106 hearing request will not be accepted. If the claimant wishes to
107 have eligibility reconsidered, he or she may reapply.
108 (ii) If a claimant or representative requests a
109 hearing in writing during the advance notice period before
110 benefits are reduced or terminated, benefits must be continued or
111 reinstated to the benefit level in effect before the effective
112 date of the adverse action. Benefits will continue at the
113 original level until the final hearing decision is rendered. Any
114 hearing requested after the advance notice period will not be
115 accepted as a timely request in order for continuation of benefits
116 to apply.
117 (iii) Upon receipt of a written request for a
118 hearing, the request will be acknowledged in writing within twenty
119 (20) days and a hearing scheduled. The claimant or representative

120 will be given at least five (5) days' advance notice of the
121 hearing date. The local and/or state level hearings will be held
122 by telephone unless, at the hearing officer's discretion, it is
123 determined that an in-person hearing is necessary. If a local
124 hearing is requested, the regional office will notify the claimant
125 or representative in writing of the time of the local hearing. If
126 a state hearing is requested, the state office will notify the
127 claimant or representative in writing of the time of the state
128 hearing. If an in-person hearing is necessary, local hearings
129 will be held at the regional office and state hearings will be
130 held at the state office unless other arrangements are
131 necessitated by the claimant's inability to travel.

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

136 (v) A state or local hearing request may be
137 withdrawn at any time before the scheduled hearing, or after the
138 hearing is held but before a decision is rendered. The withdrawal
139 must be in writing and signed by the claimant or representative.
140 A hearing request will be considered abandoned if the claimant or
141 representative fails to appear at a scheduled hearing without good
142 cause. If no one appears for a hearing, the appropriate office
143 will notify the claimant in writing that the hearing is dismissed
144 unless good cause is shown for not attending. The proposed agency

145 action will be taken on the case following failure to appear for a
146 hearing if the action has not already been effected.

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

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

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

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

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

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

162 (vii) When a request for a local hearing is
163 received by the regional office or if the regional office is
164 notified by the state office that a local hearing has been
165 requested, the Medicaid specialist supervisor in the regional
166 office will review the case record, reexamine the action taken on
167 the case, and determine if policy and procedures have been
168 followed. If any adjustments or corrections should be made, the
169 Medicaid specialist supervisor will ensure that corrective action

170 is taken. If the request for hearing was timely made such that
171 continuation of benefits applies, the Medicaid specialist
172 supervisor will ensure that benefits continue at the level before
173 the proposed adverse action that is the subject of the appeal.
174 The Medicaid specialist supervisor will also ensure that all
175 needed information, verification, and evidence is in the case
176 record for the hearing.

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

187 (ix) The Medicaid specialist supervisor will serve
188 as the hearing officer for a local hearing unless the Medicaid
189 specialist supervisor actually participated in the eligibility,
190 benefits, or services decision under appeal, in which case the
191 Medicaid specialist supervisor must appoint a Medicaid specialist
192 in the regional office who did not actually participate in the
193 decision under appeal to serve as hearing officer. The local
194 hearing will be an informal proceeding in which the claimant or

195 representative may present new or additional information, may
196 question the action taken on the client's case, and will hear an
197 explanation from agency staff as to the regulations and
198 requirements that were applied to claimant's case in making the
199 decision.

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

215 (xi) The claimant has the right to appeal a local
216 hearing decision by requesting a state hearing in writing within
217 fifteen (15) days of the mailing date of the notice of local
218 hearing decision. The state hearing request should be made to the
219 regional office. If benefits have been continued pending the

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

234 (xii) When a request for a state hearing is
235 received in the regional office, the request will be made part of
236 the case record and the regional office will prepare the case
237 record and forward it to the appropriate division in the state
238 office within five (5) days of receipt of the state hearing
239 request. A request for a state hearing received in the state
240 office will be forwarded to the regional office for inclusion in
241 the case record and the regional office will prepare the case
242 record and forward it to the appropriate division in the state
243 office within five (5) days of receipt of the state hearing
244 request.

245 (xiii) Upon receipt of the hearing record, an
246 impartial hearing officer will be assigned to hear the case either
247 by the Executive Director of the Division of Medicaid or his or
248 her designee. Hearing officers will be individuals with
249 appropriate expertise employed by the division and who have not
250 been involved in any way with the action or decision on appeal in
251 the case. The hearing officer will review the case record and if
252 the review shows that an error was made in the action of the
253 agency or in the interpretation of policy, or that a change of
254 policy has been made, the hearing officer will discuss these
255 matters with the appropriate agency personnel and request that an
256 appropriate adjustment be made. Appropriate agency personnel will
257 discuss the matter with the claimant and if the claimant is
258 agreeable to the adjustment of the claim, then agency personnel
259 will request in writing dismissal of the hearing and the reason
260 therefor, to be placed in the case record. If the hearing is to
261 go forward, it shall be scheduled by the hearing officer in the
262 manner set forth in subparagraph (iii) of this paragraph (e).
263 (xiv) In conducting the hearing, the state hearing
264 officer will inform those present of the following:
265 (A) That the hearing will be recorded on tape
266 and that a transcript of the proceedings will be typed for the
267 record;
268 (B) The action taken by the agency which
269 prompted the appeal;

270 (C) An explanation of the claimant's rights
271 during the hearing as outlined in subparagraph (vi) of this
272 paragraph (e);
273 (D) That the purpose of the hearing is for
274 the claimant to express dissatisfaction and present additional
275 information or evidence;
276 (E) That the case record is available for
277 review by the claimant or representative during the hearing;
278 (F) That the final hearing decision will be
279 rendered by the Executive Director of the Division of Medicaid on
280 the basis of facts presented at the hearing and the case record
281 and that the claimant will be notified by letter of the final
282 decision.
283 (xv) During the hearing, the claimant and/or
284 representative will be allowed an opportunity to make a full
285 statement concerning the appeal and will be assisted, if
286 necessary, in disclosing all information on which the claim is
287 based. All persons representing the claimant and those
288 representing the Division of Medicaid will have the opportunity to
289 state all facts pertinent to the appeal. The hearing officer may
290 recess or continue the hearing for a reasonable time should
291 additional information or facts be required or if some change in
292 the claimant's circumstances occurs during the hearing process
293 which impacts the appeal. When all information has been

294 presented, the hearing officer will close the hearing and stop the
295 recorder.

296 (xvi) Immediately following the hearing the
297 hearing tape will be transcribed and a copy of the transcription
298 forwarded to the regional office for filing in the case record.
299 As soon as possible, the hearing officer shall review the evidence
300 and record of the proceedings, testimony, exhibits, and other
301 supporting documents, prepare a written summary of the facts as
302 the hearing officer finds them, and prepare a written
303 recommendation of action to be taken by the agency, citing
304 appropriate policy and regulations that govern the recommendation.
305 The decision cannot be based on any material, oral or written, not
306 available to the claimant before or during the hearing. The
307 hearing officer's recommendation will become part of the case
308 record which will be submitted to the Executive Director of the
309 Division of Medicaid for further review and decision.

310 (xvii) The Executive Director of the Division of
311 Medicaid, upon review of the recommendation, proceedings and the
312 record, may sustain the recommendation of the hearing officer,
313 reject the same, or remand the matter to the hearing officer to
314 take additional testimony and evidence, in which case, the hearing
315 officer thereafter shall submit to the executive director a new
316 recommendation. The executive director shall prepare a written
317 decision summarizing the facts and identifying policies and
318 regulations that support the decision, which shall be mailed to

319 the claimant and the representative, with a copy to the regional
320 office if appropriate, as soon as possible after submission of a
321 recommendation by the hearing officer. The decision notice will
322 specify any action to be taken by the agency, specify any revised
323 eligibility dates or, if continuation of benefits applies, will
324 notify the claimant of the new effective date of reduction or
325 termination of benefits or services, which will be fifteen (15)
326 days from the mailing date of the notice of decision. The
327 decision rendered by the Executive Director of the Division of
328 Medicaid is final and binding. The claimant is entitled to seek
329 judicial review in a court of proper jurisdiction.
330 (xviii) The Division of Medicaid must take final
331 administrative action on a hearing, whether state or local, within
332 ninety (90) days from the date of the initial request for a
333 hearing.
334 (xix) A group hearing may be held for a number of
335 claimants under the following circumstances:
336 (A) The Division of Medicaid may consolidate
337 the cases and conduct a single group hearing when the only issue
338 involved is one (1) of a single law or agency policy;
339 (B) The claimants may request a group hearing
340 when there is one (1) issue of agency policy common to all of
341 them.
342 In all group hearings, whether initiated by the Division of
343 Medicaid or by the claimants, the policies governing fair hearings

344 must be followed. Each claimant in a group hearing must be
345 permitted to present his or her own case and be represented by his
346 or her own representative, or to withdraw from the group hearing
347 and have his or her appeal heard individually. As in individual
348 hearings, the hearing will be conducted only on the issue being
349 appealed, and each claimant will be expected to keep individual
350 testimony within a reasonable time frame as a matter of
351 consideration to the other claimants involved.

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

360 (4) The Executive Director of the Division of Medicaid, with
361 the approval of the Governor, shall be authorized to employ
362 eligibility, technical, clerical and supportive staff as may be
363 required in carrying out and fully implementing the determination
364 of Medicaid eligibility, including conducting quality control
365 reviews and the investigation of the improper receipt of medical
366 assistance. Staffing needs will be set forth in the annual
367 appropriation act for the division. Additional office space as

368 needed in performing eligibility, quality control and
369 investigative functions shall be obtained by the division.
370 (5) In determining Medicaid eligibility, the Division of
371 Medicaid shall verify eligibility for assistance before awarding
372 assistance and shall not rely on a potential beneficiary's
373 self-attestation of residency, household income, assets or other
374 relevant factors. For purposes of this chapter,
375 "self-attestation" shall mean the act of a person affirming
376 through an electronic or written signature that the statements the
377 person made when applying for Medicaid eligibility are truthful
378 and correct.
379 **SECTION 2.** This act shall take effect and be in force from
380 and after July 1, 2024.