

By: Senator(s) Bryan

To: Public Health and
Welfare; Appropriations

SENATE BILL NO. 3212

1 AN ACT TO AMEND SECTION 43-13-145, MISSISSIPPI CODE OF 1972,
2 TO PROVIDE FOR AN ANNUAL ASSESSMENT IMPOSED ON EACH HOSPITAL
3 LICENSED IN THE STATE BASED UPON NON-MEDICARE HOSPITAL INPATIENT
4 DAYS IN THE 2006 MEDICARE COST REPORT WITH CERTAIN CONDITIONS; TO
5 DELETE THE PRESENT PER BED ASSESSMENT LEVIED ON HOSPITALS; TO
6 AMEND SECTION 43-13-117, MISSISSIPPI CODE OF 1972, TO ESTABLISH
7 THE MEDICAID HOSPITAL ADVISORY BOARD AND PROVIDE FOR ITS
8 ORGANIZATION; TO CREATE THE MISSISSIPPI HOSPITAL FUND IN THE STATE
9 TREASURY; TO PROVIDE THAT THE FUND SHALL RECEIVE MONIES DERIVED
10 FROM THE HOSPITAL ASSESSMENT ALONG WITH FEDERAL MATCHING FUNDS AND
11 TO MAKE DISBURSEMENTS TO HOSPITALS PARTICIPATING IN THE MEDICAID
12 DISPROPORTIONATE SHARE HOSPITAL (DSH) PROGRAM, THE MEDICARE UPPER
13 PAYMENT LIMITS (UPL) PROGRAM AND FOR MAKING ANY PAYMENTS
14 REIMBURSABLE TO THE FEDERAL GOVERNMENT; TO CLARIFY THAT PAYMENTS
15 TO HOSPITALS UNDER THE DISPROPORTIONATE SHARE HOSPITAL (DSH)
16 PROGRAM AND THE UPPER PAYMENT LIMITS (UPL) PROGRAM SHALL BE MADE
17 AS PERMITTED BY FEDERAL REGULATIONS; TO PROVIDE THAT THE
18 METHODOLOGY AND RATE DETERMINATIONS FOR CROSSOVER CLAIMS FOR DUAL
19 ELIGIBLES SHALL REMAIN THE SAME AS IN EFFECT ON JANUARY 1, 2008;
20 TO AMEND SECTION 43-13-143, MISSISSIPPI CODE OF 1972, TO CONFORM
21 THERETO; TO BRING FORWARD SECTIONS 43-13-101, 43-13-103,
22 43-13-105, 43-13-107, 43-13-109, 43-13-111, 43-13-113, 43-13-115,
23 43-13-116, 43-13-117.1, 43-13-117.2, 43-13-117.3, 43-13-118,
24 43-13-120, 43-13-121, 43-13-122, 43-13-123, 43-13-125, 43-13-126,
25 43-13-127, 43-13-129, 43-13-131, 43-13-133, 43-13-137, 43-13-139,
26 43-13-213 AND 43-13-223, MISSISSIPPI CODE OF 1972, OF THE
27 MISSISSIPPI MEDICAID LAW, FOR THE PURPOSES OF AMENDMENT; AND FOR
28 RELATED PURPOSES.

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

30 **SECTION 1.** Section 43-13-145, Mississippi Code of 1972, is
31 amended as follows:

32 43-13-145. (1) (a) Upon each nursing facility licensed by
33 the State of Mississippi, there is levied an assessment in an
34 amount set by the division, not exceeding the maximum rate allowed
35 by federal law or regulation, for each licensed and occupied bed
36 of the facility.



37 (b) A nursing facility is exempt from the assessment
38 levied under this subsection if the facility is operated under the
39 direction and control of:

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

42 (ii) The State Veterans Affairs Board;

43 (iii) The University of Mississippi Medical
44 Center; or

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

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

53 (b) An intermediate care facility for the mentally
54 retarded is exempt from the assessment levied under this
55 subsection if the facility is operated under the direction and
56 control of:

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

59 (ii) The State Veterans Affairs Board; or

60 (iii) The University of Mississippi Medical
61 Center.

62 (3) (a) Upon each psychiatric residential treatment
63 facility licensed by the State of Mississippi, there is levied an
64 assessment in an amount set by the division, not exceeding the
65 maximum rate allowed by federal law or regulation, for each
66 licensed and occupied bed of the facility.

67 (b) A psychiatric residential treatment facility is
68 exempt from the assessment levied under this subsection if the
69 facility is operated under the direction and control of:



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

72 (ii) The University of Mississippi Medical Center;

73 (iii) A state agency or a state facility that
74 either provides its own state match through intergovernmental
75 transfer or certification of funds to the division.

76 (4) Hospital Assessment.

77 (a) Subject to and upon fulfillment of the requirements
78 and conditions of subsection (f) below, effective July 1, 2008, an
79 annual assessment is imposed on each hospital licensed in the
80 state in an amount equal to One Hundred Fifty-five Dollars
81 (\$155.00) per non-Medicare hospital inpatient day as stated in the
82 2006 Medicare cost report. There shall be no increase or change
83 in the rate or calculation of hospital assessments except as
84 provided in this subsection.

85 (b) Payment and definitions.

86 (i) Payment. The division shall develop and
87 publish to all hospitals a prescribed assessment calculation form
88 which shall be completed and submitted to the division by each
89 hospital to the division no later than June 1 of each year
90 beginning June 1, 2008. Upon approval by the Centers for Medicare
91 and Medicaid Services (CMS), as provided in Section 43-13-117(24),
92 the assessment shall be paid in quarterly installments due ten
93 (10) days following payment of the Disproportionate Share Hospital
94 (DSH) and Medicare Upper Payment Limits (UPL) payments required by
95 Section 43-13-117(18).

96 (ii) Definitions. For purposes of this subsection
97 (4):

98 1. "Non-Medicare hospital inpatient day"
99 means total hospital inpatient days excluding Medicare inpatient
100 days.

101 2. "Hospital inpatient day" means the number
102 of days of care charged to a beneficiary for inpatient hospital



103 care services in units of full days. A day begins at midnight and
104 ends twenty-four (24) hours later. A part of a day, including the
105 day of admission and day on which a patient returns from leave of
106 absence, counts as a full day. However, the day of discharge,
107 death, or a day on which a patient begins a leave of absence is
108 not counted as a day unless discharge or death occur on the day of
109 admission. If admission and discharge or death occur on the same
110 day, the day is considered a day of admission and counts as one
111 (1) inpatient day.

112 (c) Nothing in this act shall be construed to authorize
113 any state agency, division or department, or county, municipality
114 or other local governmental unit to license for revenue, levy or
115 impose any tax, fee or assessment upon hospitals in this state.

116 (d) Hospitals operated by the United States Department
117 of Veterans Affairs shall not be subject to the Hospital
118 Assessment provided in this subsection.

119 (e) Multihospital systems, closure, merger and new
120 hospitals:

121 (i) If a hospital conducts, operates or maintains
122 more than one (1) hospital licensed by the State Department of
123 Health, the provider shall pay the hospital assessment for each
124 hospital separately.

125 (ii) Notwithstanding any other provision in this
126 section, if a hospital subject to this assessment operates or
127 conducts business only for a portion of a fiscal year, the
128 assessment for the state fiscal year in which the cessation occurs
129 shall be adjusted by multiplying the assessment computed under
130 subsection (24) of this section by a fraction, the numerator of
131 which is the number of days in the year during which the hospital
132 operates, and the denominator of which is three hundred sixty-five
133 (365). Immediately upon ceasing to operate, the hospital shall
134 pay the assessment for the year as so adjusted (to the extent not
135 previously paid).



136 (f) Applicability.

137 (i) The hospital assessment imposed by this
138 subsection shall not take effect and/or shall cease to be imposed,
139 and any monies remaining in the fund shall be refunded to
140 hospitals in proportion to the amounts paid by them plus an amount
141 equal to ten percent (10%) of the amount paid by such hospital,
142 if:

143 1. The State Plan amendments required by
144 paragraphs (18) (a) and (18) (b) of Section 43-13-117 are not
145 submitted by the Division of Medicaid as recommended by the
146 Medicaid Hospital Advisory Board and are not approved by the
147 Centers for Medicare and Medicaid Services (CMS); or

148 2. The sum of the total expenditures for
149 hospital payments under the medical assistance program is less
150 than the amount expended in state fiscal year 2007; or

151 3. The division makes changes in its rules
152 that reduce the hospital inpatient or outpatient payment rates
153 without receiving a recommendation from the Hospital Advisory
154 Board; or

155 4. Except as provided in paragraph (24) of
156 Section 43-13-117, the disproportionate share hospital (DSH) and
157 upper payment limit (UPL) payments to hospitals required under
158 subsection (18) of Section 43-13-117 are changed or are not
159 eligible for federal matching funds under Title XIX or XXI of the
160 Social Security Act.

161 (ii) The hospital assessment imposed by this
162 subsection shall not take effect and/or shall cease to be imposed
163 if the assessment is determined to be an impermissible tax under
164 Title XIX of the Social Security Act. Monies in the Hospital
165 Provider Fund derived from assessments imposed prior to such
166 determination shall be disbursed in accordance with the State Plan
167 to the extent federal matching is not reduced due to the
168 impermissibility of the assessments, and any remaining monies



169 shall be refunded to hospitals in proportion to the amounts paid
170 by them.

171 (g) This subsection (4) is repealed on June 30, 2012.

172 (5) Each health care facility that is subject to the
173 provisions of this section shall keep and preserve such suitable
174 books and records as may be necessary to determine the amount of
175 assessment for which it is liable under this section. The books
176 and records shall be kept and preserved for a period of not less
177 than five (5) years, and those books and records shall be open for
178 examination during business hours by the division, the State Tax
179 Commission, the Office of the Attorney General and the State
180 Department of Health.

181 (6) The assessment levied under this section shall be
182 collected by the division each month beginning on March 31, 2005.

183 (7) All assessments collected under this section shall be
184 deposited in the Medical Care Fund created by Section 43-13-143.

185 (8) The assessment levied under this section shall be in
186 addition to any other assessments, taxes or fees levied by law,
187 and the assessment shall constitute a debt due the State of
188 Mississippi from the time the assessment is due until it is paid.

189 (9) (a) If a health care facility that is liable for
190 payment of an assessment levied by the division does not pay the
191 assessment when it is due, the division shall give written notice
192 to the health care facility by certified or registered mail
193 demanding payment of the assessment within ten (10) days from the
194 date of delivery of the notice. If the health care facility
195 fails or refuses to pay the assessment after receiving the notice
196 and demand from the division, the division shall withhold from any
197 Medicaid reimbursement payments that are due to the health care
198 facility the amount of the unpaid assessment and a penalty of ten
199 percent (10%) of the amount of the assessment, plus the legal rate
200 of interest until the assessment is paid in full. If the health
201 care facility does not participate in the Medicaid program, the



202 division shall turn over to the Office of the Attorney General the
203 collection of the unpaid assessment by civil action. In any such
204 civil action, the Office of the Attorney General shall collect the
205 amount of the unpaid assessment and a penalty of ten percent (10%)
206 of the amount of the assessment, plus the legal rate of interest
207 until the assessment is paid in full.

208 (b) As an additional or alternative method for
209 collecting unpaid assessments levied by the division, if a health
210 care facility fails or refuses to pay the assessment after
211 receiving notice and demand from the division, the division may
212 file a notice of a tax lien with the circuit clerk of the county
213 in which the health care facility is located, for the amount of
214 the unpaid assessment and a penalty of ten percent (10%) of the
215 amount of the assessment, plus the legal rate of interest until
216 the assessment is paid in full. Immediately upon receipt of
217 notice of the tax lien for the assessment, the circuit clerk shall
218 enter the notice of the tax lien as a judgment upon the judgment
219 roll and show in the appropriate columns the name of the health
220 care facility as judgment debtor, the name of the division as
221 judgment creditor, the amount of the unpaid assessment, and the
222 date and time of enrollment. The judgment shall be valid as
223 against mortgagees, pledgees, entrusters, purchasers, judgment
224 creditors and other persons from the time of filing with the
225 clerk. The amount of the judgment shall be a debt due the State
226 of Mississippi and remain a lien upon the tangible property of the
227 health care facility until the judgment is satisfied. The
228 judgment shall be the equivalent of any enrolled judgment of a
229 court of record and shall serve as authority for the issuance of
230 writs of execution, writs of attachment or other remedial writs.

231 **SECTION 2.** Section 43-13-117, Mississippi Code of 1972, as
232 amended by Senate Bill No. 2904, 2008 Regular Session, is amended
233 as follows:



234 43-13-117. Medicaid as authorized by this article shall
235 include payment of part or all of the costs, at the discretion of
236 the division, with approval of the Governor, of the following
237 types of care and services rendered to eligible applicants who
238 have been determined to be eligible for that care and services,
239 within the limits of state appropriations and federal matching
240 funds:

241 (1) Inpatient hospital services.

242 (a) The division shall allow thirty (30) days of
243 inpatient hospital care annually for all Medicaid recipients.
244 Medicaid recipients requiring transplants shall not have those
245 days included in the transplant case rate count against the
246 thirty-day limit for inpatient hospital care. Precertification of
247 inpatient days must be obtained as required by the division. The
248 division may allow unlimited days in disproportionate hospitals as
249 defined by the division for eligible infants and children under
250 the age of six (6) years if certified as medically necessary as
251 required by the division.

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

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

265 (d) Inpatient hospital rates shall be determined
266 as provided in the State Plan for Medical Assistance ("the State



267 Health Plan") in effect January 1, 2008, except as provided in
268 paragraph 24(d) of this section.

269 (2) Outpatient hospital services.

270 (a) Emergency services. The division shall allow
271 six (6) medically necessary emergency room visits per beneficiary
272 per fiscal year.

273 (b) Other outpatient hospital services. The
274 division shall allow benefits for other medically necessary
275 outpatient hospital services (such as chemotherapy, radiation,
276 surgery and therapy). Where the same services are reimbursed as
277 clinic services, the division may revise the rate or methodology
278 of outpatient reimbursement to maintain consistency, efficiency,
279 economy and quality of care, subject to the requirements of
280 paragraph (24) (d) of this section.

281 (3) Laboratory and x-ray services.

282 (4) Nursing facility services.

283 (a) The division shall make full payment to
284 nursing facilities for each day, not exceeding fifty-two (52) days
285 per year, that a patient is absent from the facility on home
286 leave. Payment may be made for the following home leave days in
287 addition to the fifty-two-day limitation: Christmas, the day
288 before Christmas, the day after Christmas, Thanksgiving, the day
289 before Thanksgiving and the day after Thanksgiving.

290 (b) From and after July 1, 1997, the division
291 shall implement the integrated case-mix payment and quality
292 monitoring system, which includes the fair rental system for
293 property costs and in which recapture of depreciation is
294 eliminated. The division may reduce the payment for hospital
295 leave and therapeutic home leave days to the lower of the case-mix
296 category as computed for the resident on leave using the
297 assessment being utilized for payment at that point in time, or a
298 case-mix score of 1.000 for nursing facilities, and shall compute
299 case-mix scores of residents so that only services provided at the



300 nursing facility are considered in calculating a facility's per
301 diem.

302 (c) From and after July 1, 1997, all state-owned
303 nursing facilities shall be reimbursed on a full reasonable cost
304 basis.

305 (d) When a facility of a category that does not
306 require a certificate of need for construction and that could not
307 be eligible for Medicaid reimbursement is constructed to nursing
308 facility specifications for licensure and certification, and the
309 facility is subsequently converted to a nursing facility under a
310 certificate of need that authorizes conversion only and the
311 applicant for the certificate of need was assessed an application
312 review fee based on capital expenditures incurred in constructing
313 the facility, the division shall allow reimbursement for capital
314 expenditures necessary for construction of the facility that were
315 incurred within the twenty-four (24) consecutive calendar months
316 immediately preceding the date that the certificate of need
317 authorizing the conversion was issued, to the same extent that
318 reimbursement would be allowed for construction of a new nursing
319 facility under a certificate of need that authorizes that
320 construction. The reimbursement authorized in this subparagraph
321 (d) may be made only to facilities the construction of which was
322 completed after June 30, 1989. Before the division shall be
323 authorized to make the reimbursement authorized in this
324 subparagraph (d), the division first must have received approval
325 from the Centers for Medicare and Medicaid Services (CMS) of the
326 change in the state Medicaid plan providing for the reimbursement.

327 (e) The division shall develop and implement, not
328 later than January 1, 2001, a case-mix payment add-on determined
329 by time studies and other valid statistical data that will
330 reimburse a nursing facility for the additional cost of caring for
331 a resident who has a diagnosis of Alzheimer's or other related
332 dementia and exhibits symptoms that require special care. Any



333 such case-mix add-on payment shall be supported by a determination
334 of additional cost. The division shall also develop and implement
335 as part of the fair rental reimbursement system for nursing
336 facility beds, an Alzheimer's resident bed depreciation enhanced
337 reimbursement system that will provide an incentive to encourage
338 nursing facilities to convert or construct beds for residents with
339 Alzheimer's or other related dementia.

340 (f) The division shall develop and implement an
341 assessment process for long-term care services. The division may
342 provide the assessment and related functions directly or through
343 contract with the area agencies on aging.

344 The division shall apply for necessary federal waivers to
345 assure that additional services providing alternatives to nursing
346 facility care are made available to applicants for nursing
347 facility care.

348 (5) Periodic screening and diagnostic services for
349 individuals under age twenty-one (21) years as are needed to
350 identify physical and mental defects and to provide health care
351 treatment and other measures designed to correct or ameliorate
352 defects and physical and mental illness and conditions discovered
353 by the screening services, regardless of whether these services
354 are included in the State Plan. The division may include in its
355 periodic screening and diagnostic program those discretionary
356 services authorized under the federal regulations adopted to
357 implement Title XIX of the federal Social Security Act, as
358 amended. The division, in obtaining physical therapy services,
359 occupational therapy services, and services for individuals with
360 speech, hearing and language disorders, may enter into a
361 cooperative agreement with the State Department of Education for
362 the provision of those services to handicapped students by public
363 school districts using state funds that are provided from the
364 appropriation to the Department of Education to obtain federal
365 matching funds through the division. The division, in obtaining



366 medical and psychological evaluations for children in the custody
367 of the Mississippi Department of Human Services may enter into a
368 cooperative agreement with the Mississippi Department of Human
369 Services for the provision of those services using state funds
370 that are provided from the appropriation to the Department of
371 Human Services to obtain federal matching funds through the
372 division.

373 (6) Physician's services. The division shall allow
374 twelve (12) physician visits annually. All fees for physicians'
375 services that are covered only by Medicaid shall be reimbursed at
376 ninety percent (90%) of the rate established on January 1, 1999,
377 and as may be adjusted each July thereafter, under Medicare (Title
378 XVIII of the federal Social Security Act, as amended). The
379 division may develop and implement a different reimbursement model
380 or schedule for physician's services provided by physicians based
381 at an academic health care center and by physicians at rural
382 health centers that are associated with an academic health care
383 center.

384 (7) (a) Home health services for eligible persons, not
385 to exceed in cost the prevailing cost of nursing facility
386 services, not to exceed twenty-five (25) visits per year. All
387 home health visits must be precertified as required by the
388 division.

389 (b) [Repealed]

390 (8) Emergency medical transportation services. On
391 January 1, 1994, emergency medical transportation services shall
392 be reimbursed at seventy percent (70%) of the rate established
393 under Medicare (Title XVIII of the federal Social Security Act, as
394 amended). "Emergency medical transportation services" shall mean,
395 but shall not be limited to, the following services by a properly
396 permitted ambulance operated by a properly licensed provider in
397 accordance with the Emergency Medical Services Act of 1974
398 (Section 41-59-1 et seq.): (i) basic life support, (ii) advanced



399 life support, (iii) mileage, (iv) oxygen, (v) intravenous fluids,
400 (vi) disposable supplies, (vii) similar services.

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

403 The division shall establish a mandatory preferred drug list.
404 Drugs not on the mandatory preferred drug list shall be made
405 available by utilizing prior authorization procedures established
406 by the division.

407 The division may seek to establish relationships with other
408 states in order to lower acquisition costs of prescription drugs
409 to include single source and innovator multiple source drugs or
410 generic drugs. In addition, if allowed by federal law or
411 regulation, the division may seek to establish relationships with
412 and negotiate with other countries to facilitate the acquisition
413 of prescription drugs to include single source and innovator
414 multiple source drugs or generic drugs, if that will lower the
415 acquisition costs of those prescription drugs.

416 The division shall allow for a combination of prescriptions
417 for single source and innovator multiple source drugs and generic
418 drugs to meet the needs of the beneficiaries, not to exceed five
419 (5) prescriptions per month for each noninstitutionalized Medicaid
420 beneficiary, with not more than two (2) of those prescriptions
421 being for single source or innovator multiple source drugs.

422 The executive director may approve specific maintenance drugs
423 for beneficiaries with certain medical conditions, which may be
424 prescribed and dispensed in three-month supply increments.

425 Drugs prescribed for a resident of a psychiatric residential
426 treatment facility must be provided in true unit doses when
427 available. The division may require that drugs not covered by
428 Medicare Part D for a resident of a long-term care facility be
429 provided in true unit doses when available. Those drugs that were
430 originally billed to the division but are not used by a resident
431 in any of those facilities shall be returned to the billing



432 pharmacy for credit to the division, in accordance with the
433 guidelines of the State Board of Pharmacy and any requirements of
434 federal law and regulation. Drugs shall be dispensed to a
435 recipient and only one (1) dispensing fee per month may be
436 charged. The division shall develop a methodology for reimbursing
437 for restocked drugs, which shall include a restock fee as
438 determined by the division not exceeding Seven Dollars and
439 Eighty-two Cents (\$7.82).

440 The voluntary preferred drug list shall be expanded to
441 function in the interim in order to have a manageable prior
442 authorization system, thereby minimizing disruption of service to
443 beneficiaries.

444 Except for those specific maintenance drugs approved by the
445 executive director, the division shall not reimburse for any
446 portion of a prescription that exceeds a thirty-one-day supply of
447 the drug based on the daily dosage.

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

452 All claims for drugs for dually eligible Medicare/Medicaid
453 beneficiaries that are paid for by Medicare must be submitted to
454 Medicare for payment before they may be processed by the
455 division's online payment system.

456 The division shall develop a pharmacy policy in which drugs
457 in tamper-resistant packaging that are prescribed for a resident
458 of a nursing facility but are not dispensed to the resident shall
459 be returned to the pharmacy and not billed to Medicaid, in
460 accordance with guidelines of the State Board of Pharmacy.

461 The division shall develop and implement a method or methods
462 by which the division will provide on a regular basis to Medicaid
463 providers who are authorized to prescribe drugs, information about
464 the costs to the Medicaid program of single source drugs and



465 innovator multiple source drugs, and information about other drugs
466 that may be prescribed as alternatives to those single source
467 drugs and innovator multiple source drugs and the costs to the
468 Medicaid program of those alternative drugs.

469 Notwithstanding any law or regulation, information obtained
470 or maintained by the division regarding the prescription drug
471 program, including trade secrets and manufacturer or labeler
472 pricing, is confidential and not subject to disclosure except to
473 other state agencies.

474 (b) Payment by the division for covered
475 multisource drugs shall be limited to the lower of the upper
476 limits established and published by the Centers for Medicare and
477 Medicaid Services (CMS) plus a dispensing fee, or the estimated
478 acquisition cost (EAC) as determined by the division, plus a
479 dispensing fee, or the providers' usual and customary charge to
480 the general public.

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

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

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

494 The division shall not reimburse for single source or
495 innovator multiple source drugs if there are equally effective
496 generic equivalents available and if the generic equivalents are
497 the least expensive.



498 It is the intent of the Legislature that the pharmacists
499 providers be reimbursed for the reasonable costs of filling and
500 dispensing prescriptions for Medicaid beneficiaries.

501 (10) (a) Dental care that is an adjunct to treatment
502 of an acute medical or surgical condition; services of oral
503 surgeons and dentists in connection with surgery related to the
504 jaw or any structure contiguous to the jaw or the reduction of any
505 fracture of the jaw or any facial bone; and emergency dental
506 extractions and treatment related thereto. On July 1, 2007, fees
507 for dental care and surgery under authority of this paragraph (10)
508 shall be reimbursed as provided in paragraph (b). It is the
509 intent of the Legislature that this rate revision for dental
510 services will be an incentive designed to increase the number of
511 dentists who actively provide Medicaid services. This dental
512 services rate revision shall be known as the "James Russell Dumas
513 Medicaid Dental Incentive Program."

514 The division shall annually determine the effect of this
515 incentive by evaluating the number of dentists who are Medicaid
516 providers, the number who and the degree to which they are
517 actively billing Medicaid, the geographic trends of where dentists
518 are offering what types of Medicaid services and other statistics
519 pertinent to the goals of this legislative intent. This data
520 shall be presented to the Chair of the Senate Public Health and
521 Welfare Committee and the Chair of the House Medicaid Committee.

522 (b) The Division of Medicaid shall establish a fee
523 schedule, to be effective from and after July 1, 2007, for dental
524 services. The schedule shall provide for a fee for each dental
525 service that is equal to a percentile of normal and customary
526 private provider fees, as defined by the Ingenix Customized Fee
527 Analyzer Report, which percentile shall be determined by the
528 division. The schedule shall be reviewed annually by the division
529 and dental fees shall be adjusted to reflect the percentile
530 determined by the division.



531 (c) For fiscal year 2008, the amount of state
532 funds appropriated for reimbursement for dental care and surgery
533 shall be increased by ten percent (10%) of the amount of state
534 fund expenditures for that purpose for fiscal year 2007. For each
535 of fiscal years 2009 and 2010, the amount of state funds
536 appropriated for reimbursement for dental care and surgery shall
537 be increased by ten percent (10%) of the amount of state fund
538 expenditures for that purpose for the preceding fiscal year.

539 (d) The division shall establish an annual benefit
540 limit of Two Thousand Five Hundred Dollars (\$2,500.00) in dental
541 expenditures per Medicaid-eligible recipient; however, a recipient
542 may exceed the annual limit on dental expenditures provided in
543 this paragraph with prior approval of the division.

544 (e) The division shall include dental services as
545 a necessary component of overall health services provided to
546 children who are eligible for services.

547 (f) This paragraph (10) shall stand repealed on
548 July 1, 2010.

549 (11) Eyeglasses for all Medicaid beneficiaries who have
550 (a) had surgery on the eyeball or ocular muscle that results in a
551 vision change for which eyeglasses or a change in eyeglasses is
552 medically indicated within six (6) months of the surgery and is in
553 accordance with policies established by the division, or (b) one
554 (1) pair every five (5) years and in accordance with policies
555 established by the division. In either instance, the eyeglasses
556 must be prescribed by a physician skilled in diseases of the eye
557 or an optometrist, whichever the beneficiary may select.

558 (12) Intermediate care facility services.

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



564 eighty-four-day limitation: Christmas, the day before Christmas,
565 the day after Christmas, Thanksgiving, the day before Thanksgiving
566 and the day after Thanksgiving.

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

570 (13) Family planning services, including drugs,
571 supplies and devices, when those services are under the
572 supervision of a physician or nurse practitioner.

573 (14) Clinic services. Such diagnostic, preventive,
574 therapeutic, rehabilitative or palliative services furnished to an
575 outpatient by or under the supervision of a physician or dentist
576 in a facility that is not a part of a hospital but that is
577 organized and operated to provide medical care to outpatients.
578 Clinic services shall include any services reimbursed as
579 outpatient hospital services that may be rendered in such a
580 facility, including those that become so after July 1, 1991. On
581 July 1, 1999, all fees for physicians' services reimbursed under
582 authority of this paragraph (14) shall be reimbursed at ninety
583 percent (90%) of the rate established on January 1, 1999, and as
584 may be adjusted each July thereafter, under Medicare (Title XVIII
585 of the federal Social Security Act, as amended). The division may
586 develop and implement a different reimbursement model or schedule
587 for physician's services provided by physicians based at an
588 academic health care center and by physicians at rural health
589 centers that are associated with an academic health care center.

590 (15) Home- and community-based services for the elderly
591 and disabled, as provided under Title XIX of the federal Social
592 Security Act, as amended, under waivers, subject to the
593 availability of funds specifically appropriated for that purpose
594 by the Legislature.

595 (16) Mental health services. Approved therapeutic and
596 case management services (a) provided by an approved regional



597 mental health/retardation center established under Sections
598 41-19-31 through 41-19-39, or by another community mental health
599 service provider meeting the requirements of the Department of
600 Mental Health to be an approved mental health/retardation center
601 if determined necessary by the Department of Mental Health, using
602 state funds that are provided from the appropriation to the State
603 Department of Mental Health and/or funds transferred to the
604 department by a political subdivision or instrumentality of the
605 state and used to match federal funds under a cooperative
606 agreement between the division and the department, or (b) provided
607 by a facility that is certified by the State Department of Mental
608 Health to provide therapeutic and case management services, to be
609 reimbursed on a fee for service basis, or (c) provided in the
610 community by a facility or program operated by the Department of
611 Mental Health. Any such services provided by a facility described
612 in subparagraph (b) must have the prior approval of the division
613 to be reimbursable under this section. After June 30, 1997,
614 mental health services provided by regional mental
615 health/retardation centers established under Sections 41-19-31
616 through 41-19-39, or by hospitals as defined in Section 41-9-3(a)
617 and/or their subsidiaries and divisions, or by psychiatric
618 residential treatment facilities as defined in Section 43-11-1, or
619 by another community mental health service provider meeting the
620 requirements of the Department of Mental Health to be an approved
621 mental health/retardation center if determined necessary by the
622 Department of Mental Health, shall not be included in or provided
623 under any capitated managed care pilot program provided for under
624 paragraph (24) of this section.

625 (17) Durable medical equipment services and medical
626 supplies. Precertification of durable medical equipment and
627 medical supplies must be obtained as required by the division.
628 The Division of Medicaid may require durable medical equipment



629 providers to obtain a surety bond in the amount and to the
630 specifications as established by the Balanced Budget Act of 1997.

631 (18) (a) Disproportionate share hospital program.
632 Notwithstanding any other provision of this section to the
633 contrary, the division shall operate a Disproportionate Share
634 Hospital (DSH) program and make additional reimbursement on a
635 quarterly basis to hospitals that serve a disproportionate share
636 of low-income patients and that meet the federal requirements for
637 those payments as provided in Section 1923 of the federal Social
638 Security Act and any applicable regulations. It is the intent of
639 the Legislature that the division shall draw down all available
640 federal funds allotted to the state for disproportionate share
641 hospitals and make DSH payments to eligible hospitals on a
642 quarterly basis. As permitted by federal regulations and pursuant
643 to subsection (24)(d) below, * * * public hospitals participating
644 in the DSH program may be required to participate in an
645 intergovernmental transfer program as provided in Section 1903 of
646 the federal Social Security Act and any applicable regulations.
647 The formula and method of calculation for the DSH payments made
648 pursuant to this subsection shall be prescribed pursuant to an
649 amendment to the State Plan, which shall be submitted by the
650 Division of Medicaid as recommended by the Medicaid Hospital
651 Advisory Board as provided in paragraph (24)(d) of this section.
652 The DSH payments to hospitals shall commence July 1, 2008, or, in
653 the event CMS approval of the State Plan amendments required by
654 this subsection is not obtained by June 10, 2008, on the first day
655 of the quarter immediately following such approval.

656 (b) Upper Payment Limits Program. The division
657 shall establish a Medicare Upper Payment Limits Program (UPL), as
658 defined in Section 1902(a)(30) of the federal Social Security Act
659 and any applicable federal regulations, for hospitals, and may
660 establish a Medicare Upper Payment Limits Program for nursing
661 facilities. * * * If the program is established for nursing



662 facilities, the division shall assess each nursing facility, based
663 on Medicaid utilization or other appropriate method consistent
664 with federal regulations. The nursing facility assessment will
665 remain in effect as long as the state participates in the Medicare
666 Upper Payment Limits Program for nursing facilities. The division
667 shall make the maximum allowable hospital UPL payments on a
668 quarterly basis to hospitals and, if the program is established
669 for nursing facilities, shall make additional reimbursement to
670 nursing facilities, for the Medicare Upper Payment Limits, as
671 defined in Section 1902(a)(30) of the federal Social Security Act
672 and any applicable federal regulations. The UPL payments to
673 hospitals shall commence July 1, 2008, or, in the event CMS
674 approval of the State Plan amendments required by this subsection
675 is not obtained by June 10, 2008, on the first day of the quarter
676 immediately following such approval. The formula and method of
677 calculation for the UPL payments to hospitals made pursuant to
678 this subsection shall be prescribed by the division pursuant to an
679 amendment to the State Plan submitted by the division as
680 recommended by the Medicaid Hospital Advisory Board as provided in
681 paragraph (24)(d) of this section.

682 (19) (a) Perinatal risk management services. The
683 division shall promulgate regulations to be effective from and
684 after October 1, 1988, to establish a comprehensive perinatal
685 system for risk assessment of all pregnant and infant Medicaid
686 recipients and for management, education and follow-up for those
687 who are determined to be at risk. Services to be performed
688 include case management, nutrition assessment/counseling,
689 psychosocial assessment/counseling and health education.

690 (b) Early intervention system services. The
691 division shall cooperate with the State Department of Health,
692 acting as lead agency, in the development and implementation of a
693 statewide system of delivery of early intervention services, under
694 Part C of the Individuals with Disabilities Education Act (IDEA).



695 The State Department of Health shall certify annually in writing
696 to the executive director of the division the dollar amount of
697 state early intervention funds available that will be utilized as
698 a certified match for Medicaid matching funds. Those funds then
699 shall be used to provide expanded targeted case management
700 services for Medicaid eligible children with special needs who are
701 eligible for the state's early intervention system.

702 Qualifications for persons providing service coordination shall be
703 determined by the State Department of Health and the Division of
704 Medicaid.

705 (20) Home- and community-based services for physically
706 disabled approved services as allowed by a waiver from the United
707 States Department of Health and Human Services for home- and
708 community-based services for physically disabled people using
709 state funds that are provided from the appropriation to the State
710 Department of Rehabilitation Services and used to match federal
711 funds under a cooperative agreement between the division and the
712 department, provided that funds for these services are
713 specifically appropriated to the Department of Rehabilitation
714 Services.

715 (21) Nurse practitioner services. Services furnished
716 by a registered nurse who is licensed and certified by the
717 Mississippi Board of Nursing as a nurse practitioner, including,
718 but not limited to, nurse anesthetists, nurse midwives, family
719 nurse practitioners, family planning nurse practitioners,
720 pediatric nurse practitioners, obstetrics-gynecology nurse
721 practitioners and neonatal nurse practitioners, under regulations
722 adopted by the division. Reimbursement for those services shall
723 not exceed ninety percent (90%) of the reimbursement rate for
724 comparable services rendered by a physician.

725 (22) Ambulatory services delivered in federally
726 qualified health centers, rural health centers and clinics of the
727 local health departments of the State Department of Health for



728 individuals eligible for Medicaid under this article based on
729 reasonable costs as determined by the division.

730 (23) Inpatient psychiatric services. Inpatient
731 psychiatric services to be determined by the division for
732 recipients under age twenty-one (21) that are provided under the
733 direction of a physician in an inpatient program in a licensed
734 acute care psychiatric facility or in a licensed psychiatric
735 residential treatment facility, before the recipient reaches age
736 twenty-one (21) or, if the recipient was receiving the services
737 immediately before he or she reached age twenty-one (21), before
738 the earlier of the date he or she no longer requires the services
739 or the date he or she reaches age twenty-two (22), as provided by
740 federal regulations. Precertification of inpatient days and
741 residential treatment days must be obtained as required by the
742 division.

743 (24) Mississippi Hospital Fund; Medicaid Hospital
744 Advisory Board.

745 (a) There is created in the State Treasury the
746 Mississippi Hospital Fund. Interest earned by the fund shall be
747 credited to the fund. The fund shall not be used to replace any
748 monies appropriated to the Medicaid program by the Legislature.

749 (b) The fund is created for the sole purpose of
750 receiving monies derived from the Hospital Assessment provided in
751 subsection (4) of Section 43-13-145, along with matching federal
752 funds attributable to such assessments and, notwithstanding any
753 other provision of law, disbursing monies only for the following
754 purposes:

755 (i) Ninety Million Dollars (\$90,000,000.00)
756 and proportionate federal matching funds to the division for
757 reimbursement of services covered under this section.

758 (ii) For the reimbursement of monies
759 collected by the division from hospitals through error or mistake
760 in performing the activities authorized under this subsection.



761 (iii) For making DSH payments pursuant to
762 paragraph (18) (a) of this section.

763 (iv) For making UPL payments to hospitals
764 pursuant to paragraph (18) (b) of this section.

765 (v) For repayment of any amounts paid to
766 hospitals from the fund which are determined to be reimbursable to
767 the federal government.

768 (vi) For making refunds to hospitals pursuant
769 to Section 43-13-145(4) (f).

770 (c) The fund shall consist of the following:

771 (i) All monies collected or received by the
772 division from the hospital assessments imposed by Section
773 43-13-145(4).

774 (ii) All federal matching funds received by
775 the division as a result of expenditures made by the division that
776 are attributable to monies deposited in the fund.

777 (iii) Any interest or penalty levied in
778 conjunction with the administration of the fund, the DSH program,
779 or the UPL program.

780 (d) Medicaid Hospital Advisory Board:

781 (i) There is hereby created the Medicaid
782 Hospital Advisory Board, the purpose of which is to provide advice
783 and assistance to the division with regard to matters affecting
784 hospitals participating in the Mississippi Medicaid program as
785 provided in paragraph (24) (d) (iii).

786 (ii) Appointments, qualifications and terms:

787 The Medicaid Hospital Advisory Board shall consist of seven (7)
788 members who shall be currently affiliated with a licensed
789 Mississippi hospital participating in the Mississippi Medicaid
790 program or the Mississippi Hospital Association and who shall be
791 appointed as provided in this paragraph (d). The Governor shall
792 appoint four (4) members nominated by the Mississippi Hospital
793 Association, two (2) of whom shall serve an initial term of two



794 (2) years and two (2) of whom shall serve an initial term of four
795 (4) years. The Governor shall appoint three (3) additional
796 members, who shall serve an initial term of three (3) years. All
797 initial and subsequent appointments shall be subject to the advice
798 and consent of the Senate. All subsequent appointments shall be
799 made in the manner in this paragraph and shall be for a term of
800 four (4) years and continue until their successors are appointed
801 and commence service. An appointment to fill a vacancy which
802 arises other than by expiration of a term of office shall be for
803 the unexpired term only. Members may be reappointed in the same
804 manner as initial appointments. The Lieutenant Governor may
805 designate a Senator, and the Speaker of the House of
806 Representatives may designate a member of the House, to attend
807 meetings of the Medicaid Hospital Advisory Board for the sole
808 purpose of observing the actions of the board and making reports
809 to the Legislature.

810 (iii) Powers and duties. The powers and
811 duties of the Medicaid Hospital Advisory Board shall be:

812 1. To consult with and provide advice to
813 the division with regard to Medicaid operations affecting
814 participating hospitals.

815 2. To review, and provide
816 recommendations on, any and all changes or amendments to the State
817 Plan affecting hospital reimbursement, which recommendations must
818 be given prior to submission for approval by the Centers for
819 Medicare and Medicaid Services (CMS).

820 3. To review, and make recommendations
821 on, the State Plan amendments regarding formula and method of
822 calculation for disproportionate share hospital payments made
823 pursuant to subsection (18) (a) of this section and Medicare Upper
824 Payment Limits payments made pursuant to subsection (18) (b) of
825 this section, which recommendations must be given prior to
826 submission for approval by CMS.



827 4. To review, and make recommendations
828 on, all State Plan amendments regarding reimbursement for
829 inpatient and outpatient hospital services.

830 5. To adopt rules and procedures
831 governing the times and places for meeting, requirements for
832 giving notices of meetings and governing the manner of conducting
833 the board's business, which rules will be consistent with the
834 Mississippi Open Meetings Law, Section 25-41-1 et seq., and the
835 Mississippi Public Records Law, Section 25-61-1, et seq.

836 6. To collect data and statistical
837 information and calculate and propose for approval by the division
838 payments to hospitals pursuant to paragraphs (18) (a) and (18) (b)
839 of this section pursuant to applicable federal regulations and
840 subject to approval of the division.

841 7. To contract with consultants to
842 provide administrative support, data collection, calculations and
843 methodology for calculation for hospital DSH and UPL programs,
844 required by paragraphs (18) (a) and (18) (b) of this section,
845 provided that the fees and expenses for such contract shall not be
846 borne by the state. Such consultant, its employees and
847 subcontractors shall be entitled to the protections of Section
848 11-46-1 et seq. solely for the purposes of the performance of this
849 contract.

850 (iv) There shall be a chairman and vice
851 chairman of the board, elected by and from the membership of the
852 board; and the chairman shall be the presiding officer of the
853 board, and be responsible for causing minutes to be kept, and for
854 giving all required notices. Decisions of the board concerning
855 State Plan amendments shall be made by two-thirds (2/3) vote of
856 the seven (7) members. All other decisions shall be made by a
857 majority vote of the seven members.



858 (v) The members of the board shall receive no
859 annual salary and per diem compensation and expenses shall be
860 borne by the member or his or her employer.

861 (e) This subsection (24) shall stand repealed on
862 June 30, 2012.

863 (25) [Deleted]

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

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

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

882 (29) The Division of Medicaid may apply for a waiver
883 from the United States Department of Health and Human Services for
884 home- and community-based services for developmentally disabled
885 people using state funds that are provided from the appropriation
886 to the State Department of Mental Health and/or funds transferred
887 to the department by a political subdivision or instrumentality of
888 the state and used to match federal funds under a cooperative
889 agreement between the division and the department, provided that
890 funds for these services are specifically appropriated to the



891 Department of Mental Health and/or transferred to the department
892 by a political subdivision or instrumentality of the state.

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

895 (31) Targeted case management services for children
896 with special needs, under waivers from the United States
897 Department of Health and Human Services, using state funds that
898 are provided from the appropriation to the Mississippi Department
899 of Human Services and used to match federal funds under a
900 cooperative agreement between the division and the department.

901 (32) Care and services provided in Christian Science
902 Sanatoria listed and certified by the Commission for Accreditation
903 of Christian Science Nursing Organizations/Facilities, Inc.,
904 rendered in connection with treatment by prayer or spiritual means
905 to the extent that those services are subject to reimbursement
906 under Section 1903 of the federal Social Security Act.

907 (33) Podiatrist services.

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

912 (35) Services and activities authorized in Sections
913 43-27-101 and 43-27-103, using state funds that are provided from
914 the appropriation to the Mississippi Department of Human Services
915 and used to match federal funds under a cooperative agreement
916 between the division and the department.

917 (36) Nonemergency transportation services for
918 Medicaid-eligible persons, to be provided by the Division of
919 Medicaid. The division may contract with additional entities to
920 administer nonemergency transportation services as it deems
921 necessary. All providers shall have a valid driver's license,
922 vehicle inspection sticker, valid vehicle license tags and a
923 standard liability insurance policy covering the vehicle. The



924 division may pay providers a flat fee based on mileage tiers, or
925 in the alternative, may reimburse on actual miles traveled. The
926 division may apply to the Center for Medicare and Medicaid
927 Services (CMS) for a waiver to draw federal matching funds for
928 nonemergency transportation services as a covered service instead
929 of an administrative cost. The PEER Committee shall conduct a
930 performance evaluation of the nonemergency transportation program
931 to evaluate the administration of the program and the providers of
932 transportation services to determine the most cost effective ways
933 of providing nonemergency transportation services to the patients
934 served under the program. The performance evaluation shall be
935 completed and provided to the members of the Senate Public Health
936 and Welfare Committee and the House Medicaid Committee not later
937 than January 15, 2008.

938 (37) [Deleted]

939 (38) Chiropractic services. A chiropractor's manual
940 manipulation of the spine to correct a subluxation, if x-ray
941 demonstrates that a subluxation exists and if the subluxation has
942 resulted in a neuromusculoskeletal condition for which
943 manipulation is appropriate treatment, and related spinal x-rays
944 performed to document these conditions. Reimbursement for
945 chiropractic services shall not exceed Seven Hundred Dollars
946 (\$700.00) per year per beneficiary.

947 (39) Dually eligible Medicare/Medicaid beneficiaries.
948 The division shall pay the Medicare deductible and coinsurance
949 amounts for services available under Medicare, as determined by
950 the division.

951 (40) [Deleted]

952 (41) Services provided by the State Department of
953 Rehabilitation Services for the care and rehabilitation of persons
954 with spinal cord injuries or traumatic brain injuries, as allowed
955 under waivers from the United States Department of Health and
956 Human Services, using up to seventy-five percent (75%) of the



957 funds that are appropriated to the Department of Rehabilitation
958 Services from the Spinal Cord and Head Injury Trust Fund
959 established under Section 37-33-261 and used to match federal
960 funds under a cooperative agreement between the division and the
961 department.

962 (42) Notwithstanding any other provision in this
963 article to the contrary, the division may develop a population
964 health management program for women and children health services
965 through the age of one (1) year. This program is primarily for
966 obstetrical care associated with low birth weight and pre-term
967 babies. The division may apply to the federal Centers for
968 Medicare and Medicaid Services (CMS) for a Section 1115 waiver or
969 any other waivers that may enhance the program. In order to
970 effect cost savings, the division may develop a revised payment
971 methodology that may include at-risk capitated payments, and may
972 require member participation in accordance with the terms and
973 conditions of an approved federal waiver.

974 (43) The division shall provide reimbursement,
975 according to a payment schedule developed by the division, for
976 smoking cessation medications for pregnant women during their
977 pregnancy and other Medicaid-eligible women who are of
978 child-bearing age.

979 (44) Nursing facility services for the severely
980 disabled.

981 (a) Severe disabilities include, but are not
982 limited to, spinal cord injuries, closed head injuries and
983 ventilator dependent patients.

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

988 (45) Physician assistant services. Services furnished
989 by a physician assistant who is licensed by the State Board of



990 Medical Licensure and is practicing with physician supervision
991 under regulations adopted by the board, under regulations adopted
992 by the division. Reimbursement for those services shall not
993 exceed ninety percent (90%) of the reimbursement rate for
994 comparable services rendered by a physician.

995 (46) The division shall make application to the federal
996 Centers for Medicare and Medicaid Services (CMS) for a waiver to
997 develop and provide services for children with serious emotional
998 disturbances as defined in Section 43-14-1(1), which may include
999 home- and community-based services, case management services or
1000 managed care services through mental health providers certified by
1001 the Department of Mental Health. The division may implement and
1002 provide services under this waived program only if funds for
1003 these services are specifically appropriated for this purpose by
1004 the Legislature, or if funds are voluntarily provided by affected
1005 agencies.

1006 (47) (a) Notwithstanding any other provision in this
1007 article to the contrary, the division may develop and implement
1008 disease management programs for individuals with high-cost chronic
1009 diseases and conditions, including the use of grants, waivers,
1010 demonstrations or other projects as necessary.

1011 (b) Participation in any disease management
1012 program implemented under this paragraph (47) is optional with the
1013 individual. An individual must affirmatively elect to participate
1014 in the disease management program in order to participate, and
1015 may elect to discontinue participation in the program at any time.

1016 (48) Pediatric long-term acute care hospital services.

1017 (a) Pediatric long-term acute care hospital
1018 services means services provided to eligible persons under
1019 twenty-one (21) years of age by a freestanding Medicare-certified
1020 hospital that has an average length of inpatient stay greater than
1021 twenty-five (25) days and that is primarily engaged in providing



1022 chronic or long-term medical care to persons under twenty-one (21)
1023 years of age.

1024 (b) The services under this paragraph (48) shall
1025 be reimbursed as a separate category of hospital services.

1026 (49) The division shall establish copayments and/or
1027 coinsurance for all Medicaid services for which copayments and/or
1028 coinsurance are allowable under federal law or regulation, and
1029 shall set the amount of the copayment and/or coinsurance for each
1030 of those services at the maximum amount allowable under federal
1031 law or regulation.

1032 (50) Services provided by the State Department of
1033 Rehabilitation Services for the care and rehabilitation of persons
1034 who are deaf and blind, as allowed under waivers from the United
1035 States Department of Health and Human Services to provide home-
1036 and community-based services using state funds that are provided
1037 from the appropriation to the State Department of Rehabilitation
1038 Services or if funds are voluntarily provided by another agency.

1039 (51) Upon determination of Medicaid eligibility and in
1040 association with annual redetermination of Medicaid eligibility,
1041 beneficiaries shall be encouraged to undertake a physical
1042 examination that will establish a base-line level of health and
1043 identification of a usual and customary source of care (a medical
1044 home) to aid utilization of disease management tools. This
1045 physical examination and utilization of these disease management
1046 tools shall be consistent with current United States Preventive
1047 Services Task Force or other recognized authority recommendations.

1048 For persons who are determined ineligible for Medicaid, the
1049 division will provide information and direction for accessing
1050 medical care and services in the area of their residence.

1051 (52) Notwithstanding any provisions of this article,
1052 the division may pay enhanced reimbursement fees related to trauma
1053 care, as determined by the division in conjunction with the State
1054 Department of Health, using funds appropriated to the State



1055 Department of Health for trauma care and services and used to
1056 match federal funds under a cooperative agreement between the
1057 division and the State Department of Health. The division, in
1058 conjunction with the State Department of Health, may use grants,
1059 waivers, demonstrations, or other projects as necessary in the
1060 development and implementation of this reimbursement program.

1061 (53) Targeted case management services for high-cost
1062 beneficiaries shall be developed by the division for all services
1063 under this section.

1064 (54) Adult foster care services pilot program. Social
1065 and protective services on a pilot program basis in an approved
1066 foster care facility for vulnerable adults who would otherwise
1067 need care in a long-term care facility, to be implemented in an
1068 area of the state with the greatest need for such program, under
1069 the Medicaid Waivers for the Elderly and Disabled program or an
1070 assisted living waiver. The division may use grants, waivers,
1071 demonstrations or other projects as necessary in the development
1072 and implementation of this adult foster care services pilot
1073 program.

1074 (55) Therapy services. The plan of care for therapy
1075 services may be developed to cover a period of treatment for up to
1076 six (6) months, but in no event shall the plan of care exceed a
1077 six-month period of treatment. The projected period of treatment
1078 must be indicated on the initial plan of care and must be updated
1079 with each subsequent revised plan of care. Based on medical
1080 necessity, the division shall approve certification periods for
1081 less than or up to six (6) months, but in no event shall the
1082 certification period exceed the period of treatment indicated on
1083 the plan of care. The appeal process for any reduction in therapy
1084 services shall be consistent with the appeal process in federal
1085 regulations.

1086 Notwithstanding any other provision of this article to the
1087 contrary, the division shall reduce the rate of reimbursement to



1088 providers for any service provided under this section by five
1089 percent (5%) of the allowed amount for that service. However, the
1090 reduction in the reimbursement rates required by this paragraph
1091 shall not apply to inpatient hospital services, nursing facility
1092 services, intermediate care facility services, psychiatric
1093 residential treatment facility services, pharmacy services
1094 provided under paragraph (9) of this section, or any service
1095 provided by the University of Mississippi Medical Center or a
1096 state agency, a state facility or a public agency that either
1097 provides its own state match through intergovernmental transfer or
1098 certification of funds to the division, or a service for which the
1099 federal government sets the reimbursement methodology and rate.
1100 In addition, the reduction in the reimbursement rates required by
1101 this paragraph shall not apply to case management services and
1102 home-delivered meals provided under the home- and community-based
1103 services program for the elderly and disabled by a planning and
1104 development district (PDD). Planning and development districts
1105 participating in the home- and community-based services program
1106 for the elderly and disabled as case management providers shall be
1107 reimbursed for case management services at the maximum rate
1108 approved by the Centers for Medicare and Medicaid Services (CMS).

1109 The division may pay to those providers who participate in
1110 and accept patient referrals from the division's emergency room
1111 redirection program a percentage, as determined by the division,
1112 of savings achieved according to the performance measures and
1113 reduction of costs required of that program. Federally qualified
1114 health centers may participate in the emergency room redirection
1115 program, and the division may pay those centers a percentage of
1116 any savings to the Medicaid program achieved by the centers'
1117 accepting patient referrals through the program, as provided in
1118 this paragraph.

1119 Notwithstanding any provision of this article, except as
1120 authorized in the following paragraph and in Section 43-13-139,



1121 neither (a) the limitations on quantity or frequency of use of or
1122 the fees or charges for any of the care or services available to
1123 recipients under this section, nor (b) the payments or rates of
1124 reimbursement to providers rendering care or services authorized
1125 under this section to recipients, may be increased, decreased or
1126 otherwise changed from the levels in effect on July 1, 1999,
1127 unless they are authorized by an amendment to this section by the
1128 Legislature. However, the restriction in this paragraph shall not
1129 prevent the division from changing the payments or rates of
1130 reimbursement to providers without an amendment to this section
1131 whenever those changes are required by federal law or regulation,
1132 or whenever those changes are necessary to correct administrative
1133 errors or omissions in calculating those payments or rates of
1134 reimbursement.

1135 Notwithstanding any provision of this article, no new groups
1136 or categories of recipients and new types of care and services may
1137 be added without enabling legislation from the Mississippi
1138 Legislature, except that the division may authorize those changes
1139 without enabling legislation when the addition of recipients or
1140 services is ordered by a court of proper authority.

1141 The executive director shall keep the Governor advised on a
1142 timely basis of the funds available for expenditure and the
1143 projected expenditures. If current or projected expenditures of
1144 the division are reasonably anticipated to exceed the amount of
1145 funds appropriated to the division for any fiscal year, the
1146 Governor, after consultation with the executive director, shall
1147 discontinue any or all of the payment of the types of care and
1148 services as provided in this section that are deemed to be
1149 optional services under Title XIX of the federal Social Security
1150 Act, as amended, and when necessary but only after first
1151 discontinuing all optional services, shall institute any other
1152 cost containment measures on any program or programs authorized
1153 under the article to the extent allowed under the federal law



1154 governing that program or programs. However, the Governor shall
1155 not be authorized to discontinue or eliminate any service under
1156 this section that is mandatory under federal law, or to
1157 discontinue or eliminate, or adjust income limits or resource
1158 limits for, any eligibility category or group under Section
1159 43-13-115. It is the intent of the Legislature that the
1160 expenditures of the division during any fiscal year shall not
1161 exceed the amounts appropriated to the division for that fiscal
1162 year.

1163 Notwithstanding any other provision of this article, it shall
1164 be the duty of each nursing facility, intermediate care facility
1165 for the mentally retarded, psychiatric residential treatment
1166 facility, and nursing facility for the severely disabled that is
1167 participating in the Medicaid program to keep and maintain books,
1168 documents and other records as prescribed by the Division of
1169 Medicaid in substantiation of its cost reports for a period of
1170 three (3) years after the date of submission to the Division of
1171 Medicaid of an original cost report, or three (3) years after the
1172 date of submission to the Division of Medicaid of an amended cost
1173 report.

1174 Notwithstanding any other provision of this article, unless
1175 required by applicable federal law, the methodology and rate
1176 determinations for hospital crossover claims for recipients
1177 eligible for both Medicare and Medicaid benefits shall remain the
1178 same as in effect as of January 1, 2008.

1179 **SECTION 3.** Section 43-13-143, Mississippi Code of 1972, is
1180 amended as follows:

1181 43-13-143. There is created in the State Treasury a special
1182 fund to be known as the "Medical Care Fund," which shall be
1183 comprised of monies transferred by public or private health care
1184 providers, governing bodies of counties, municipalities, public or
1185 community hospitals and other political subdivisions of the state,
1186 individuals, corporations, associations and any other entities for



1187 the purpose of providing health care services. Any transfer made
1188 to the fund shall be paid to the State Treasurer for deposit into
1189 the fund, and all such transfers shall be considered as
1190 unconditional transfers to the fund. The monies in the Medical
1191 Care Fund shall be expended only for health care services, and may
1192 be expended only upon appropriation of the Legislature. Except as
1193 provided in Section 43-13-117(24), all transfers of monies to the
1194 Division of Medicaid by health care providers and by governing
1195 bodies of counties, municipalities, public or community hospitals
1196 and other political subdivisions of the state shall be deposited
1197 into the fund. Unexpended monies remaining in the fund at the end
1198 of a fiscal year shall not lapse into the State General Fund, and
1199 any interest earned on monies in the fund shall be deposited to
1200 the credit of the fund.

1201 **SECTION 4.** Section 43-13-101, Mississippi Code of 1972, is
1202 brought forward as follows:

1203 43-13-101. This article shall be entitled and cited as the
1204 "Mississippi Medicaid Law."

1205 **SECTION 5.** Section 43-13-103, Mississippi Code of 1972, is
1206 brought forward as follows:

1207 43-13-103. For the purpose of affording health care and
1208 remedial and institutional services in accordance with the
1209 requirements for federal grants and other assistance under Titles
1210 XVIII, XIX and XXI of the Social Security Act, as amended, a
1211 statewide system of medical assistance is established and shall be
1212 in effect in all political subdivisions of the state, to be
1213 financed by state appropriations and federal matching funds
1214 therefor, and to be administered by the Office of the Governor as
1215 hereinafter provided.

1216 **SECTION 6.** Section 43-13-105, Mississippi Code of 1972, is
1217 brought forward as follows:

1218 43-13-105. When used in this article, the following
1219 definitions shall apply, unless the context requires otherwise:



1220 (a) "Administering agency" means the Division of
1221 Medicaid in the Office of the Governor as created by this article.

1222 (b) "Division" or "Division of Medicaid" means the
1223 Division of Medicaid in the Office of the Governor.

1224 (c) "Medical assistance" means payment of part or all
1225 of the costs of medical and remedial care provided under the terms
1226 of this article and in accordance with provisions of Titles XIX
1227 and XXI of the Social Security Act, as amended.

1228 (d) "Applicant" means a person who applies for
1229 assistance under Titles IV, XVI, XIX or XXI of the Social Security
1230 Act, as amended, and under the terms of this article.

1231 (e) "Recipient" means a person who is eligible for
1232 assistance under Title XIX or XXI of the Social Security Act, as
1233 amended and under the terms of this article.

1234 (f) "State health agency" shall mean any agency,
1235 department, institution, board or commission of the State of
1236 Mississippi, except the University Medical School, which is
1237 supported in whole or in part by any public funds, including funds
1238 directly appropriated from the State Treasury, funds derived by
1239 taxes, fees levied or collected by statutory authority, or any
1240 other funds used by "state health agencies" derived from federal
1241 sources, when any funds available to such agency are expended
1242 either directly or indirectly in connection with, or in support
1243 of, any public health, hospital, hospitalization or other public
1244 programs for the preventive treatment or actual medical treatment
1245 of persons who are physically or mentally ill or mentally
1246 retarded.

1247 (g) "Mississippi Medicaid Commission" or "Medicaid
1248 Commission" wherever they appear in the laws of the State of
1249 Mississippi, shall mean the Division of Medicaid in the Office of
1250 the Governor.

1251 **SECTION 7.** Section 43-13-107, Mississippi Code of 1972, is
1252 brought forward as follows:



1253 43-13-107. (1) The Division of Medicaid is created in the
1254 Office of the Governor and established to administer this article
1255 and perform such other duties as are prescribed by law.

1256 (2) (a) The Governor shall appoint a full-time executive
1257 director, with the advice and consent of the Senate, who shall be
1258 either (i) a physician with administrative experience in a medical
1259 care or health program, or (ii) a person holding a graduate degree
1260 in medical care administration, public health, hospital
1261 administration, or the equivalent, or (iii) a person holding a
1262 bachelor's degree in business administration or hospital
1263 administration, with at least ten (10) years' experience in
1264 management-level administration of Medicaid programs. The
1265 executive director shall be the official secretary and legal
1266 custodian of the records of the division; shall be the agent of
1267 the division for the purpose of receiving all service of process,
1268 summons and notices directed to the division; shall perform such
1269 other duties as the Governor may prescribe from time to time; and
1270 shall perform all other duties that are now or may be imposed upon
1271 him or her by law.

1272 (b) The executive director shall serve at the will and
1273 pleasure of the Governor.

1274 (c) The executive director shall, before entering upon
1275 the discharge of the duties of the office, take and subscribe to
1276 the oath of office prescribed by the Mississippi Constitution and
1277 shall file the same in the Office of the Secretary of State, and
1278 shall execute a bond in some surety company authorized to do
1279 business in the state in the penal sum of One Hundred Thousand
1280 Dollars (\$100,000.00), conditioned for the faithful and impartial
1281 discharge of the duties of the office. The premium on the bond
1282 shall be paid as provided by law out of funds appropriated to the
1283 Division of Medicaid for contractual services.

1284 (d) The executive director, with the approval of the
1285 Governor and subject to the rules and regulations of the State



1286 Personnel Board, shall employ such professional, administrative,
1287 stenographic, secretarial, clerical and technical assistance as
1288 may be necessary to perform the duties required in administering
1289 this article and fix the compensation for those persons, all in
1290 accordance with a state merit system meeting federal requirements.
1291 When the salary of the executive director is not set by law, that
1292 salary shall be set by the State Personnel Board. No employees of
1293 the Division of Medicaid shall be considered to be staff members
1294 of the immediate Office of the Governor; however, the provisions
1295 of Section 25-9-107(c) (xv) shall apply to the executive director
1296 and other administrative heads of the division.

1297 (3) (a) There is established a Medical Care Advisory
1298 Committee, which shall be the committee that is required by
1299 federal regulation to advise the Division of Medicaid about health
1300 and medical care services.

1301 (b) The advisory committee shall consist of not less
1302 than eleven (11) members, as follows:

1303 (i) The Governor shall appoint five (5) members,
1304 one (1) from each congressional district and one (1) from the
1305 state at large;

1306 (ii) The Lieutenant Governor shall appoint three
1307 (3) members, one (1) from each Supreme Court district;

1308 (iii) The Speaker of the House of Representatives
1309 shall appoint three (3) members, one (1) from each Supreme Court
1310 district.

1311 All members appointed under this paragraph shall either be
1312 health care providers or consumers of health care services. One
1313 (1) member appointed by each of the appointing authorities shall
1314 be a board certified physician.

1315 (c) The respective Chairmen of the House Medicaid
1316 Committee, the House Public Health and Human Services Committee,
1317 the House Appropriations Committee, the Senate Public Health and
1318 Welfare Committee and the Senate Appropriations Committee, or



1319 their designees, two (2) members of the State Senate appointed by
1320 the Lieutenant Governor and one (1) member of the House of
1321 Representatives appointed by the Speaker of the House, shall serve
1322 as ex officio nonvoting members of the advisory committee.

1323 (d) In addition to the committee members required by
1324 paragraph (b), the advisory committee shall consist of such other
1325 members as are necessary to meet the requirements of the federal
1326 regulation applicable to the advisory committee, who shall be
1327 appointed as provided in the federal regulation.

1328 (e) The chairmanship of the advisory committee shall be
1329 elected by the voting members of the committee annually and shall
1330 not serve more than two (2) consecutive years as chairman.

1331 (f) The members of the advisory committee specified in
1332 paragraph (b) shall serve for terms that are concurrent with the
1333 terms of members of the Legislature, and any member appointed
1334 under paragraph (b) may be reappointed to the advisory committee.
1335 The members of the advisory committee specified in paragraph (b)
1336 shall serve without compensation, but shall receive reimbursement
1337 to defray actual expenses incurred in the performance of committee
1338 business as authorized by law. Legislators shall receive per diem
1339 and expenses, which may be paid from the contingent expense funds
1340 of their respective houses in the same amounts as provided for
1341 committee meetings when the Legislature is not in session.

1342 (g) The advisory committee shall meet not less than
1343 quarterly, and advisory committee members shall be furnished
1344 written notice of the meetings at least ten (10) days before the
1345 date of the meeting.

1346 (h) The executive director shall submit to the advisory
1347 committee all amendments, modifications and changes to the state
1348 plan for the operation of the Medicaid program, for review by the
1349 advisory committee before the amendments, modifications or changes
1350 may be implemented by the division.



1351 (i) The advisory committee, among its duties and
1352 responsibilities, shall:

1353 (i) Advise the division with respect to
1354 amendments, modifications and changes to the state plan for the
1355 operation of the Medicaid program;

1356 (ii) Advise the division with respect to issues
1357 concerning receipt and disbursement of funds and eligibility for
1358 Medicaid;

1359 (iii) Advise the division with respect to
1360 determining the quantity, quality and extent of medical care
1361 provided under this article;

1362 (iv) Communicate the views of the medical care
1363 professions to the division and communicate the views of the
1364 division to the medical care professions;

1365 (v) Gather information on reasons that medical
1366 care providers do not participate in the Medicaid program and
1367 changes that could be made in the program to encourage more
1368 providers to participate in the Medicaid program, and advise the
1369 division with respect to encouraging physicians and other medical
1370 care providers to participate in the Medicaid program;

1371 (vi) Provide a written report on or before
1372 November 30 of each year to the Governor, Lieutenant Governor and
1373 Speaker of the House of Representatives.

1374 (4) (a) There is established a Drug Use Review Board, which
1375 shall be the board that is required by federal law to:

1376 (i) Review and initiate retrospective drug use,
1377 review including ongoing periodic examination of claims data and
1378 other records in order to identify patterns of fraud, abuse, gross
1379 overuse, or inappropriate or medically unnecessary care, among
1380 physicians, pharmacists and individuals receiving Medicaid
1381 benefits or associated with specific drugs or groups of drugs.

1382 (ii) Review and initiate ongoing interventions for
1383 physicians and pharmacists, targeted toward therapy problems or



1384 individuals identified in the course of retrospective drug use
1385 reviews.

1386 (iii) On an ongoing basis, assess data on drug use
1387 against explicit predetermined standards using the compendia and
1388 literature set forth in federal law and regulations.

1389 (b) The board shall consist of not less than twelve
1390 (12) members appointed by the Governor, or his designee.

1391 (c) The board shall meet at least quarterly, and board
1392 members shall be furnished written notice of the meetings at least
1393 ten (10) days before the date of the meeting.

1394 (d) The board meetings shall be open to the public,
1395 members of the press, legislators and consumers. Additionally,
1396 all documents provided to board members shall be available to
1397 members of the Legislature in the same manner, and shall be made
1398 available to others for a reasonable fee for copying. However,
1399 patient confidentiality and provider confidentiality shall be
1400 protected by blinding patient names and provider names with
1401 numerical or other anonymous identifiers. The board meetings
1402 shall be subject to the Open Meetings Act (Section 25-41-1 et
1403 seq.). Board meetings conducted in violation of this section
1404 shall be deemed unlawful.

1405 (5) (a) There is established a Pharmacy and Therapeutics
1406 Committee, which shall be appointed by the Governor, or his
1407 designee.

1408 (b) The committee shall meet at least quarterly, and
1409 committee members shall be furnished written notice of the
1410 meetings at least ten (10) days before the date of the meeting.

1411 (c) The committee meetings shall be open to the public,
1412 members of the press, legislators and consumers. Additionally,
1413 all documents provided to committee members shall be available to
1414 members of the Legislature in the same manner, and shall be made
1415 available to others for a reasonable fee for copying. However,
1416 patient confidentiality and provider confidentiality shall be



1417 protected by blinding patient names and provider names with
1418 numerical or other anonymous identifiers. The committee meetings
1419 shall be subject to the Open Meetings Act (Section 25-41-1 et
1420 seq.). Committee meetings conducted in violation of this section
1421 shall be deemed unlawful.

1422 (d) After a thirty-day public notice, the executive
1423 director, or his or her designee, shall present the division's
1424 recommendation regarding prior approval for a therapeutic class of
1425 drugs to the committee. However, in circumstances where the
1426 division deems it necessary for the health and safety of Medicaid
1427 beneficiaries, the division may present to the committee its
1428 recommendations regarding a particular drug without a thirty-day
1429 public notice. In making that presentation, the division shall
1430 state to the committee the circumstances that precipitate the need
1431 for the committee to review the status of a particular drug
1432 without a thirty-day public notice. The committee may determine
1433 whether or not to review the particular drug under the
1434 circumstances stated by the division without a thirty-day public
1435 notice. If the committee determines to review the status of the
1436 particular drug, it shall make its recommendations to the
1437 division, after which the division shall file those
1438 recommendations for a thirty-day public comment under the
1439 provisions of Section 25-43-7(1).

1440 (e) Upon reviewing the information and recommendations,
1441 the committee shall forward a written recommendation approved by a
1442 majority of the committee to the executive director or his or her
1443 designee. The decisions of the committee regarding any
1444 limitations to be imposed on any drug or its use for a specified
1445 indication shall be based on sound clinical evidence found in
1446 labeling, drug compendia, and peer reviewed clinical literature
1447 pertaining to use of the drug in the relevant population.

1448 (f) Upon reviewing and considering all recommendations
1449 including recommendation of the committee, comments, and data, the



1450 executive director shall make a final determination whether to
1451 require prior approval of a therapeutic class of drugs, or modify
1452 existing prior approval requirements for a therapeutic class of
1453 drugs.

1454 (g) At least thirty (30) days before the executive
1455 director implements new or amended prior authorization decisions,
1456 written notice of the executive director's decision shall be
1457 provided to all prescribing Medicaid providers, all Medicaid
1458 enrolled pharmacies, and any other party who has requested the
1459 notification. However, notice given under Section 25-43-7(1) will
1460 substitute for and meet the requirement for notice under this
1461 subsection.

1462 (h) Members of the committee shall dispose of matters
1463 before the committee in an unbiased and professional manner. If a
1464 matter being considered by the committee presents a real or
1465 apparent conflict of interest for any member of the committee,
1466 that member shall disclose the conflict in writing to the
1467 committee chair and recuse himself or herself from any discussions
1468 and/or actions on the matter.

1469 (6) This section shall stand repealed on July 1, 2009.

1470 **SECTION 8.** Section 43-13-109, Mississippi Code of 1972, is
1471 brought forward as follows:

1472 43-13-109. The director, with the approval of the Governor
1473 and pursuant to the rules and regulations of the State Personnel
1474 Board, may adopt reasonable rules and regulations to provide for
1475 an open, competitive or qualifying examination for all employees
1476 of the division other than the director, part-time consultants and
1477 professional staff members.

1478 **SECTION 9.** Section 43-13-111, Mississippi Code of 1972, is
1479 brought forward as follows:

1480 43-13-111. Every state health agency, as defined in Section
1481 43-13-105, shall obtain an appropriation of state funds from the
1482 State Legislature for all medical assistance programs rendered by



1483 the agency and shall organize its programs and budgets in such a
1484 manner as to secure maximum federal funding through the Division
1485 of Medicaid under Title XIX or Title XXI of the federal Social
1486 Security Act, as amended.

1487 **SECTION 10.** Section 43-13-113, Mississippi Code of 1972, is
1488 brought forward as follows:

1489 43-13-113. (1) The State Treasurer shall receive on behalf
1490 of the state, and execute all instruments incidental thereto,
1491 federal and other funds to be used for financing the medical
1492 assistance plan or program adopted pursuant to this article, and
1493 place all such funds in a special account to the credit of the
1494 Governor's Office-Division of Medicaid, which funds shall be
1495 expended by the division for the purposes and under the provisions
1496 of this article, and shall be paid out by the State Treasurer as
1497 funds appropriated to carry out the provisions of this article are
1498 paid out by him.

1499 The division shall issue all checks or electronic transfers
1500 for administrative expenses, and for medical assistance under the
1501 provisions of this article. All such checks or electronic
1502 transfers shall be drawn upon funds made available to the division
1503 by the State Auditor, upon requisition of the director. It is the
1504 purpose of this section to provide that the State Auditor shall
1505 transfer, in lump sums, amounts to the division for disbursement
1506 under the regulations which shall be made by the director with the
1507 approval of the Governor; however, the division, or its fiscal
1508 agent in behalf of the division, shall be authorized in
1509 maintaining separate accounts with a Mississippi bank to handle
1510 claim payments, refund recoveries and related Medicaid program
1511 financial transactions, to aggressively manage the float in these
1512 accounts while awaiting clearance of checks or electronic
1513 transfers and/or other disposition so as to accrue maximum
1514 interest advantage of the funds in the account, and to retain all



1515 earned interest on these funds to be applied to match federal
1516 funds for Medicaid program operations.

1517 (2) The division is authorized to obtain a line of credit
1518 through the State Treasurer from the Working Cash-Stabilization
1519 Fund or any other special source funds maintained in the State
1520 Treasury in an amount not exceeding One Hundred Fifty Million
1521 Dollars (\$150,000,000.00) to fund shortfalls which, from time to
1522 time, may occur due to decreases in state matching fund cash flow.
1523 The length of indebtedness under this provision shall not carry
1524 past the end of the quarter following the loan origination. Loan
1525 proceeds shall be received by the State Treasurer and shall be
1526 placed in a Medicaid designated special fund account. Loan
1527 proceeds shall be expended only for health care services provided
1528 under the Medicaid program. The division may pledge as security
1529 for such interim financing future funds that will be received by
1530 the division. Any such loans shall be repaid from the first
1531 available funds received by the division in the manner of and
1532 subject to the same terms provided in this section.

1533 In the event the State Treasurer makes a determination that
1534 special source funds are not sufficient to cover a line of credit
1535 for the Division of Medicaid, the division is authorized to obtain
1536 a line of credit, in an amount not exceeding One Hundred Fifty
1537 Million Dollars (\$150,000,000.00), from a commercial lender or a
1538 consortium of lenders. The length of indebtedness under this
1539 provision shall not carry past the end of the quarter following
1540 the loan origination. The division shall obtain a minimum of two
1541 (2) written quotes that shall be presented to the State Fiscal
1542 Officer and State Treasurer, who shall jointly select a lender.
1543 Loan proceeds shall be received by the State Treasurer and shall
1544 be placed in a Medicaid designated special fund account. Loan
1545 proceeds shall be expended only for health care services provided
1546 under the Medicaid program. The division may pledge as security
1547 for such interim financing future funds that will be received by



1548 the division. Any such loans shall be repaid from the first
1549 available funds received by the division in the manner of and
1550 subject to the same terms provided in this section.

1551 (3) Disbursement of funds to providers shall be made as
1552 follows:

1553 (a) All providers must submit all claims to the
1554 Division of Medicaid's fiscal agent no later than twelve (12)
1555 months from the date of service.

1556 (b) The Division of Medicaid's fiscal agent must pay
1557 ninety percent (90%) of all clean claims within thirty (30) days
1558 of the date of receipt.

1559 (c) The Division of Medicaid's fiscal agent must pay
1560 ninety-nine percent (99%) of all clean claims within ninety (90)
1561 days of the date of receipt.

1562 (d) The Division of Medicaid's fiscal agent must pay
1563 all other claims within twelve (12) months of the date of receipt.

1564 (e) If a claim is neither paid nor denied for valid and
1565 proper reasons by the end of the time periods as specified above,
1566 the Division of Medicaid's fiscal agent must pay the provider
1567 interest on the claim at the rate of one and one-half percent
1568 (1-1/2%) per month on the amount of such claim until it is finally
1569 settled or adjudicated.

1570 (4) The date of receipt is the date the fiscal agent
1571 receives the claim as indicated by its date stamp on the claim or,
1572 for those claims filed electronically, the date of receipt is the
1573 date of transmission.

1574 (5) The date of payment is the date of the check or, for
1575 those claims paid by electronic funds transfer, the date of the
1576 transfer.

1577 (6) The above specified time limitations do not apply in the
1578 following circumstances:

1579 (a) Retroactive adjustments paid to providers
1580 reimbursed under a retrospective payment system;



1581 (b) If a claim for payment under Medicare has been
1582 filed in a timely manner, the fiscal agent may pay a Medicaid
1583 claim relating to the same services within six (6) months after
1584 it, or the provider, receives notice of the disposition of the
1585 Medicare claim;

1586 (c) Claims from providers under investigation for fraud
1587 or abuse; and

1588 (d) The Division of Medicaid and/or its fiscal agent
1589 may make payments at any time in accordance with a court order, to
1590 carry out hearing decisions or corrective actions taken to resolve
1591 a dispute, or to extend the benefits of a hearing decision,
1592 corrective action, or court order to others in the same situation
1593 as those directly affected by it.

1594 (7) Repealed.

1595 (8) If sufficient funds are appropriated therefor by the
1596 Legislature, the Division of Medicaid may contract with the
1597 Mississippi Dental Association, or an approved designee, to
1598 develop and operate a Donated Dental Services (DDS) program
1599 through which volunteer dentists will treat needy disabled, aged
1600 and medically-compromised individuals who are non-Medicaid
1601 eligible recipients.

1602 **SECTION 11.** Section 43-13-115, Mississippi Code of 1972, is
1603 brought forward as follows:

1604 43-13-115. Recipients of Medicaid shall be the following
1605 persons only:

1606 (1) Those who are qualified for public assistance
1607 grants under provisions of Title IV-A and E of the federal Social
1608 Security Act, as amended, including those statutorily deemed to be
1609 IV-A and low-income families and children under Section 1931 of
1610 the federal Social Security Act. For the purposes of this
1611 paragraph (1) and paragraphs (8), (17) and (18) of this section,
1612 any reference to Title IV-A or to Part A of Title IV of the
1613 federal Social Security Act, as amended, or the state plan under



1614 Title IV-A or Part A of Title IV, shall be considered as a
1615 reference to Title IV-A of the federal Social Security Act, as
1616 amended, and the state plan under Title IV-A, including the income
1617 and resource standards and methodologies under Title IV-A and the
1618 state plan, as they existed on July 16, 1996. The Department of
1619 Human Services shall determine Medicaid eligibility for children
1620 receiving public assistance grants under Title IV-E. The division
1621 shall determine eligibility for low-income families under Section
1622 1931 of the federal Social Security Act and shall redetermine
1623 eligibility for those continuing under Title IV-A grants.

1624 (2) Those qualified for Supplemental Security Income
1625 (SSI) benefits under Title XVI of the federal Social Security Act,
1626 as amended, and those who are deemed SSI eligible as contained in
1627 federal statute. The eligibility of individuals covered in this
1628 paragraph shall be determined by the Social Security
1629 Administration and certified to the Division of Medicaid.

1630 (3) Qualified pregnant women who would be eligible for
1631 Medicaid as a low-income family member under Section 1931 of the
1632 federal Social Security Act if her child were born. The
1633 eligibility of the individuals covered under this paragraph shall
1634 be determined by the division.

1635 (4) [Deleted]

1636 (5) A child born on or after October 1, 1984, to a
1637 woman eligible for and receiving Medicaid under the state plan on
1638 the date of the child's birth shall be deemed to have applied for
1639 Medicaid and to have been found eligible for Medicaid under the
1640 plan on the date of that birth, and will remain eligible for
1641 Medicaid for a period of one (1) year so long as the child is a
1642 member of the woman's household and the woman remains eligible for
1643 Medicaid or would be eligible for Medicaid if pregnant. The
1644 eligibility of individuals covered in this paragraph shall be
1645 determined by the Division of Medicaid.



1646 (6) Children certified by the State Department of Human
1647 Services to the Division of Medicaid of whom the state and county
1648 departments of human services have custody and financial
1649 responsibility, and children who are in adoptions subsidized in
1650 full or part by the Department of Human Services, including
1651 special needs children in non-Title IV-E adoption assistance, who
1652 are approvable under Title XIX of the Medicaid program. The
1653 eligibility of the children covered under this paragraph shall be
1654 determined by the State Department of Human Services.

1655 (7) Persons certified by the Division of Medicaid who
1656 are patients in a medical facility (nursing home, hospital,
1657 tuberculosis sanatorium or institution for treatment of mental
1658 diseases), and who, except for the fact that they are patients in
1659 that medical facility, would qualify for grants under Title IV,
1660 Supplementary Security Income (SSI) benefits under Title XVI or
1661 state supplements, and those aged, blind and disabled persons who
1662 would not be eligible for Supplemental Security Income (SSI)
1663 benefits under Title XVI or state supplements if they were not
1664 institutionalized in a medical facility but whose income is below
1665 the maximum standard set by the Division of Medicaid, which
1666 standard shall not exceed that prescribed by federal regulation.

1667 (8) Children under eighteen (18) years of age and
1668 pregnant women (including those in intact families) who meet the
1669 financial standards of the state plan approved under Title IV-A of
1670 the federal Social Security Act, as amended. The eligibility of
1671 children covered under this paragraph shall be determined by the
1672 Division of Medicaid.

1673 (9) Individuals who are:

1674 (a) Children born after September 30, 1983, who
1675 have not attained the age of nineteen (19), with family income
1676 that does not exceed one hundred percent (100%) of the nonfarm
1677 official poverty level;



1678 (b) Pregnant women, infants and children who have
1679 not attained the age of six (6), with family income that does not
1680 exceed one hundred thirty-three percent (133%) of the federal
1681 poverty level; and

1682 (c) Pregnant women and infants who have not
1683 attained the age of one (1), with family income that does not
1684 exceed one hundred eighty-five percent (185%) of the federal
1685 poverty level.

1686 The eligibility of individuals covered in (a), (b) and (c) of
1687 this paragraph shall be determined by the division.

1688 (10) Certain disabled children age eighteen (18) or
1689 under who are living at home, who would be eligible, if in a
1690 medical institution, for SSI or a state supplemental payment under
1691 Title XVI of the federal Social Security Act, as amended, and
1692 therefore for Medicaid under the plan, and for whom the state has
1693 made a determination as required under Section 1902(e)(3)(b) of
1694 the federal Social Security Act, as amended. The eligibility of
1695 individuals under this paragraph shall be determined by the
1696 Division of Medicaid.

1697 (11) Until the end of the day on December 31, 2005,
1698 individuals who are sixty-five (65) years of age or older or are
1699 disabled as determined under Section 1614(a)(3) of the federal
1700 Social Security Act, as amended, and whose income does not exceed
1701 one hundred thirty-five percent (135%) of the nonfarm official
1702 poverty level as defined by the Office of Management and Budget
1703 and revised annually, and whose resources do not exceed those
1704 established by the Division of Medicaid. The eligibility of
1705 individuals covered under this paragraph shall be determined by
1706 the Division of Medicaid. After December 31, 2005, only those
1707 individuals covered under the 1115(c) Healthier Mississippi waiver
1708 will be covered under this category.

1709 Any individual who applied for Medicaid during the period
1710 from July 1, 2004, through March 31, 2005, who otherwise would



1711 have been eligible for coverage under this paragraph (11) if it
1712 had been in effect at the time the individual submitted his or her
1713 application and is still eligible for coverage under this
1714 paragraph (11) on March 31, 2005, shall be eligible for Medicaid
1715 coverage under this paragraph (11) from March 31, 2005, through
1716 December 31, 2005. The division shall give priority in processing
1717 the applications for those individuals to determine their
1718 eligibility under this paragraph (11).

1719 (12) Individuals who are qualified Medicare
1720 beneficiaries (QMB) entitled to Part A Medicare as defined under
1721 Section 301, Public Law 100-360, known as the Medicare
1722 Catastrophic Coverage Act of 1988, and whose income does not
1723 exceed one hundred percent (100%) of the nonfarm official poverty
1724 level as defined by the Office of Management and Budget and
1725 revised annually.

1726 The eligibility of individuals covered under this paragraph
1727 shall be determined by the Division of Medicaid, and those
1728 individuals determined eligible shall receive Medicare
1729 cost-sharing expenses only as more fully defined by the Medicare
1730 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
1731 1997.

1732 (13) (a) Individuals who are entitled to Medicare Part
1733 A as defined in Section 4501 of the Omnibus Budget Reconciliation
1734 Act of 1990, and whose income does not exceed one hundred twenty
1735 percent (120%) of the nonfarm official poverty level as defined by
1736 the Office of Management and Budget and revised annually.
1737 Eligibility for Medicaid benefits is limited to full payment of
1738 Medicare Part B premiums.

1739 (b) Individuals entitled to Part A of Medicare,
1740 with income above one hundred twenty percent (120%), but less than
1741 one hundred thirty-five percent (135%) of the federal poverty
1742 level, and not otherwise eligible for Medicaid benefits, are
1743 limited to full payment of Medicare Part B premiums. The number



1744 of eligible individuals is limited by the availability of the
1745 federal capped allocation at one hundred percent (100%) of federal
1746 matching funds, as more fully defined in the Balanced Budget Act
1747 of 1997.

1748 The eligibility of individuals covered under this paragraph
1749 shall be determined by the Division of Medicaid.

1750 (14) [Deleted]

1751 (15) Disabled workers who are eligible to enroll in
1752 Part A Medicare as required by Public Law 101-239, known as the
1753 Omnibus Budget Reconciliation Act of 1989, and whose income does
1754 not exceed two hundred percent (200%) of the federal poverty level
1755 as determined in accordance with the Supplemental Security Income
1756 (SSI) program. The eligibility of individuals covered under this
1757 paragraph shall be determined by the Division of Medicaid and
1758 those individuals shall be entitled to buy-in coverage of Medicare
1759 Part A premiums only under the provisions of this paragraph (15).

1760 (16) In accordance with the terms and conditions of
1761 approved Title XIX waiver from the United States Department of
1762 Health and Human Services, persons provided home- and
1763 community-based services who are physically disabled and certified
1764 by the Division of Medicaid as eligible due to applying the income
1765 and deeming requirements as if they were institutionalized.

1766 (17) In accordance with the terms of the federal
1767 Personal Responsibility and Work Opportunity Reconciliation Act of
1768 1996 (Public Law 104-193), persons who become ineligible for
1769 assistance under Title IV-A of the federal Social Security Act, as
1770 amended, because of increased income from or hours of employment
1771 of the caretaker relative or because of the expiration of the
1772 applicable earned income disregards, who were eligible for
1773 Medicaid for at least three (3) of the six (6) months preceding
1774 the month in which the ineligibility begins, shall be eligible for
1775 Medicaid for up to twelve (12) months. The eligibility of the



1776 individuals covered under this paragraph shall be determined by
1777 the division.

1778 (18) Persons who become ineligible for assistance under
1779 Title IV-A of the federal Social Security Act, as amended, as a
1780 result, in whole or in part, of the collection or increased
1781 collection of child or spousal support under Title IV-D of the
1782 federal Social Security Act, as amended, who were eligible for
1783 Medicaid for at least three (3) of the six (6) months immediately
1784 preceding the month in which the ineligibility begins, shall be
1785 eligible for Medicaid for an additional four (4) months beginning
1786 with the month in which the ineligibility begins. The eligibility
1787 of the individuals covered under this paragraph shall be
1788 determined by the division.

1789 (19) Disabled workers, whose incomes are above the
1790 Medicaid eligibility limits, but below two hundred fifty percent
1791 (250%) of the federal poverty level, shall be allowed to purchase
1792 Medicaid coverage on a sliding fee scale developed by the Division
1793 of Medicaid.

1794 (20) Medicaid eligible children under age eighteen (18)
1795 shall remain eligible for Medicaid benefits until the end of a
1796 period of twelve (12) months following an eligibility
1797 determination, or until such time that the individual exceeds age
1798 eighteen (18).

1799 (21) Women of childbearing age whose family income does
1800 not exceed one hundred eighty-five percent (185%) of the federal
1801 poverty level. The eligibility of individuals covered under this
1802 paragraph (21) shall be determined by the Division of Medicaid,
1803 and those individuals determined eligible shall only receive
1804 family planning services covered under Section 43-13-117(13) and
1805 not any other services covered under Medicaid. However, any
1806 individual eligible under this paragraph (21) who is also eligible
1807 under any other provision of this section shall receive the
1808 benefits to which he or she is entitled under that other



1809 provision, in addition to family planning services covered under
1810 Section 43-13-117(13).

1811 The Division of Medicaid shall apply to the United States
1812 Secretary of Health and Human Services for a federal waiver of the
1813 applicable provisions of Title XIX of the federal Social Security
1814 Act, as amended, and any other applicable provisions of federal
1815 law as necessary to allow for the implementation of this paragraph
1816 (21). The provisions of this paragraph (21) shall be implemented
1817 from and after the date that the Division of Medicaid receives the
1818 federal waiver.

1819 (22) Persons who are workers with a potentially severe
1820 disability, as determined by the division, shall be allowed to
1821 purchase Medicaid coverage. The term "worker with a potentially
1822 severe disability" means a person who is at least sixteen (16)
1823 years of age but under sixty-five (65) years of age, who has a
1824 physical or mental impairment that is reasonably expected to cause
1825 the person to become blind or disabled as defined under Section
1826 1614(a) of the federal Social Security Act, as amended, if the
1827 person does not receive items and services provided under
1828 Medicaid.

1829 The eligibility of persons under this paragraph (22) shall be
1830 conducted as a demonstration project that is consistent with
1831 Section 204 of the Ticket to Work and Work Incentives Improvement
1832 Act of 1999, Public Law 106-170, for a certain number of persons
1833 as specified by the division. The eligibility of individuals
1834 covered under this paragraph (22) shall be determined by the
1835 Division of Medicaid.

1836 (23) Children certified by the Mississippi Department
1837 of Human Services for whom the state and county departments of
1838 human services have custody and financial responsibility who are
1839 in foster care on their eighteenth birthday as reported by the
1840 Mississippi Department of Human Services shall be certified



1841 Medicaid eligible by the Division of Medicaid until their
1842 twenty-first birthday.

1843 (24) Individuals who have not attained age sixty-five
1844 (65), are not otherwise covered by creditable coverage as defined
1845 in the Public Health Services Act, and have been screened for
1846 breast and cervical cancer under the Centers for Disease Control
1847 and Prevention Breast and Cervical Cancer Early Detection Program
1848 established under Title XV of the Public Health Service Act in
1849 accordance with the requirements of that act and who need
1850 treatment for breast or cervical cancer. Eligibility of
1851 individuals under this paragraph (24) shall be determined by the
1852 Division of Medicaid.

1853 (25) The division shall apply to the Centers for
1854 Medicare and Medicaid Services (CMS) for any necessary waivers to
1855 provide services to individuals who are sixty-five (65) years of
1856 age or older or are disabled as determined under Section
1857 1614(a)(3) of the federal Social Security Act, as amended, and
1858 whose income does not exceed one hundred thirty-five percent
1859 (135%) of the nonfarm official poverty level as defined by the
1860 Office of Management and Budget and revised annually, and whose
1861 resources do not exceed those established by the Division of
1862 Medicaid, and who are not otherwise covered by Medicare. Nothing
1863 contained in this paragraph (25) shall entitle an individual to
1864 benefits. The eligibility of individuals covered under this
1865 paragraph shall be determined by the Division of Medicaid.

1866 (26) The division shall apply to the Centers for
1867 Medicare and Medicaid Services (CMS) for any necessary waivers to
1868 provide services to individuals who are sixty-five (65) years of
1869 age or older or are disabled as determined under Section
1870 1614(a)(3) of the federal Social Security Act, as amended, who are
1871 end stage renal disease patients on dialysis, cancer patients on
1872 chemotherapy or organ transplant recipients on anti-rejection
1873 drugs, whose income does not exceed one hundred thirty-five



1874 percent (135%) of the nonfarm official poverty level as defined by
1875 the Office of Management and Budget and revised annually, and
1876 whose resources do not exceed those established by the division.
1877 Nothing contained in this paragraph (26) shall entitle an
1878 individual to benefits. The eligibility of individuals covered
1879 under this paragraph shall be determined by the Division of
1880 Medicaid.

1881 (27) Individuals who are entitled to Medicare Part D
1882 and whose income does not exceed one hundred fifty percent (150%)
1883 of the nonfarm official poverty level as defined by the Office of
1884 Management and Budget and revised annually. Eligibility for
1885 payment of the Medicare Part D subsidy under this paragraph shall
1886 be determined by the division.

1887 The division shall redetermine eligibility for all categories
1888 of recipients described in each paragraph of this section not less
1889 frequently than required by federal law.

1890 **SECTION 12.** Section 43-13-116, Mississippi Code of 1972, is
1891 brought forward as follows:

1892 43-13-116. (1) It shall be the duty of the Division of
1893 Medicaid to fully implement and carry out the administrative
1894 functions of determining the eligibility of those persons who
1895 qualify for medical assistance under Section 43-13-115.

1896 (2) In determining Medicaid eligibility, the Division of
1897 Medicaid is authorized to enter into an agreement with the
1898 Secretary of the Department of Health and Human Services for the
1899 purpose of securing the transfer of eligibility information from
1900 the Social Security Administration on those individuals receiving
1901 supplemental security income benefits under the federal Social
1902 Security Act and any other information necessary in determining
1903 Medicaid eligibility. The Division of Medicaid is further
1904 empowered to enter into contractual arrangements with its fiscal
1905 agent or with the State Department of Human Services in securing
1906 electronic data processing support as may be necessary.



1907 (3) Administrative hearings shall be available to any
1908 applicant who requests it because his or her claim of eligibility
1909 for services is denied or is not acted upon with reasonable
1910 promptness or by any recipient who requests it because he or she
1911 believes the agency has erroneously taken action to deny, reduce,
1912 or terminate benefits. The agency need not grant a hearing if the
1913 sole issue is a federal or state law requiring an automatic change
1914 adversely affecting some or all recipients. Eligibility
1915 determinations that are made by other agencies and certified to
1916 the Division of Medicaid pursuant to Section 43-13-115 are not
1917 subject to the administrative hearing procedures of the Division
1918 of Medicaid but are subject to the administrative hearing
1919 procedures of the agency that determined eligibility.

1920 (a) A request may be made either for a local regional
1921 office hearing or a state office hearing when the local regional
1922 office has made the initial decision that the claimant seeks to
1923 appeal or when the regional office has not acted with reasonable
1924 promptness in making a decision on a claim for eligibility or
1925 services. The only exception to requesting a local hearing is
1926 when the issue under appeal involves either (i) a disability or
1927 blindness denial, or termination, or (ii) a level of care denial
1928 or termination for a disabled child living at home. An appeal
1929 involving disability, blindness or level of care must be handled
1930 as a state level hearing. The decision from the local hearing may
1931 be appealed to the state office for a state hearing. A decision
1932 to deny, reduce or terminate benefits that is initially made at
1933 the state office may be appealed by requesting a state hearing.

1934 (b) A request for a hearing, either state or local,
1935 must be made in writing by the claimant or claimant's legal
1936 representative. "Legal representative" includes the claimant's
1937 authorized representative, an attorney retained by the claimant or
1938 claimant's family to represent the claimant, a paralegal
1939 representative with a legal aid services, a parent of a minor



1940 child if the claimant is a child, a legal guardian or conservator
1941 or an individual with power of attorney for the claimant. The
1942 claimant may also be represented by anyone that he or she so
1943 designates but must give the designation to the Medicaid regional
1944 office or state office in writing, if the person is not the legal
1945 representative, legal guardian, or authorized representative.

1946 (c) The claimant may make a request for a hearing in
1947 person at the regional office but an oral request must be put into
1948 written form. Regional office staff will determine from the
1949 claimant if a local or state hearing is requested and assist the
1950 claimant in completing and signing the appropriate form. Regional
1951 office staff may forward a state hearing request to the
1952 appropriate division in the state office or the claimant may mail
1953 the form to the address listed on the form. The claimant may make
1954 a written request for a hearing by letter. A simple statement
1955 requesting a hearing that is signed by the claimant or legal
1956 representative is sufficient; however, if possible, the claimant
1957 should state the reason for the request. The letter may be mailed
1958 to the regional office or it may be mailed to the state office. If
1959 the letter does not specify the type of hearing desired, local or
1960 state, Medicaid staff will attempt to contact the claimant to
1961 determine the level of hearing desired. If contact cannot be made
1962 within three (3) days of receipt of the request, the request will
1963 be assumed to be for a local hearing and scheduled accordingly. A
1964 hearing will not be scheduled until either a letter or the
1965 appropriate form is received by the regional or state office.

1966 (d) When both members of a couple wish to appeal an
1967 action or inaction by the agency that affects both applications or
1968 cases similarly and arose from the same issue, one or both may
1969 file the request for hearing, both may present evidence at the
1970 hearing, and the agency's decision will be applicable to both. If
1971 both file a request for hearing, two (2) hearings will be
1972 registered but they will be conducted on the same day and in the



1973 same place, either consecutively or jointly, as the couple wishes.
1974 If they so desire, only one of the couple need attend the hearing.

1975 (e) The procedure for administrative hearings shall be
1976 as follows:

1977 (i) The claimant has thirty (30) days from the
1978 date the agency mails the appropriate notice to the claimant of
1979 its decision regarding eligibility, services, or benefits to
1980 request either a state or local hearing. This time period may be
1981 extended if the claimant can show good cause for not filing within
1982 thirty (30) days. Good cause includes, but may not be limited to,
1983 illness, failure to receive the notice, being out of state, or
1984 some other reasonable explanation. If good cause can be shown, a
1985 late request may be accepted provided the facts in the case remain
1986 the same. If a claimant's circumstances have changed or if good
1987 cause for filing a request beyond thirty (30) days is not shown, a
1988 hearing request will not be accepted. If the claimant wishes to
1989 have eligibility reconsidered, he or she may reapply.

1990 (ii) If a claimant or representative requests a
1991 hearing in writing during the advance notice period before
1992 benefits are reduced or terminated, benefits must be continued or
1993 reinstated to the benefit level in effect before the effective
1994 date of the adverse action. Benefits will continue at the
1995 original level until the final hearing decision is rendered. Any
1996 hearing requested after the advance notice period will not be
1997 accepted as a timely request in order for continuation of benefits
1998 to apply.

1999 (iii) Upon receipt of a written request for a
2000 hearing, the request will be acknowledged in writing within twenty
2001 (20) days and a hearing scheduled. The claimant or representative
2002 will be given at least five (5) days' advance notice of the
2003 hearing date. The local and/or state level hearings will be held
2004 by telephone unless, at the hearing officer's discretion, it is
2005 determined that an in-person hearing is necessary. If a local



2006 hearing is requested, the regional office will notify the claimant
2007 or representative in writing of the time of the local hearing. If
2008 a state hearing is requested, the state office will notify the
2009 claimant or representative in writing of the time of the state
2010 hearing. If an in-person hearing is necessary, local hearings
2011 will be held at the regional office and state hearings will be
2012 held at the state office unless other arrangements are
2013 necessitated by the claimant's inability to travel.

2014 (iv) All persons attending a hearing will attend
2015 for the purpose of giving information on behalf of the claimant or
2016 rendering the claimant assistance in some other way, or for the
2017 purpose of representing the Division of Medicaid.

2018 (v) A state or local hearing request may be
2019 withdrawn at any time before the scheduled hearing, or after the
2020 hearing is held but before a decision is rendered. The withdrawal
2021 must be in writing and signed by the claimant or representative.
2022 A hearing request will be considered abandoned if the claimant or
2023 representative fails to appear at a scheduled hearing without good
2024 cause. If no one appears for a hearing, the appropriate office
2025 will notify the claimant in writing that the hearing is dismissed
2026 unless good cause is shown for not attending. The proposed agency
2027 action will be taken on the case following failure to appear for a
2028 hearing if the action has not already been effected.

2029 (vi) The claimant or his representative has the
2030 following rights in connection with a local or state hearing:

2031 (A) The right to examine at a reasonable time
2032 before the date of the hearing and during the hearing the content
2033 of the claimant's case record;

2034 (B) The right to have legal representation at
2035 the hearing and to bring witnesses;

2036 (C) The right to produce documentary evidence
2037 and establish all facts and circumstances concerning eligibility,
2038 services, or benefits;



2039 (D) The right to present an argument without
2040 undue interference;

2041 (E) The right to question or refute any
2042 testimony or evidence including an opportunity to confront and
2043 cross-examine adverse witnesses.

2044 (vii) When a request for a local hearing is
2045 received by the regional office or if the regional office is
2046 notified by the state office that a local hearing has been
2047 requested, the Medicaid specialist supervisor in the regional
2048 office will review the case record, reexamine the action taken on
2049 the case, and determine if policy and procedures have been
2050 followed. If any adjustments or corrections should be made, the
2051 Medicaid specialist supervisor will ensure that corrective action
2052 is taken. If the request for hearing was timely made such that
2053 continuation of benefits applies, the Medicaid specialist
2054 supervisor will ensure that benefits continue at the level before
2055 the proposed adverse action that is the subject of the appeal.
2056 The Medicaid specialist supervisor will also ensure that all
2057 needed information, verification, and evidence is in the case
2058 record for the hearing.

2059 (viii) When a state hearing is requested that
2060 appeals the action or inaction of a regional office, the regional
2061 office will prepare copies of the case record and forward it to
2062 the appropriate division in the state office no later than five
2063 (5) days after receipt of the request for a state hearing. The
2064 original case record will remain in the regional office. Either
2065 the original case record in the regional office or the copy
2066 forwarded to the state office will be available for inspection by
2067 the claimant or claimant's representative a reasonable time before
2068 the date of the hearing.

2069 (ix) The Medicaid specialist supervisor will serve
2070 as the hearing officer for a local hearing unless the Medicaid
2071 specialist supervisor actually participated in the eligibility,



2072 benefits, or services decision under appeal, in which case the
2073 Medicaid specialist supervisor must appoint a Medicaid specialist
2074 in the regional office who did not actually participate in the
2075 decision under appeal to serve as hearing officer. The local
2076 hearing will be an informal proceeding in which the claimant or
2077 representative may present new or additional information, may
2078 question the action taken on the client's case, and will hear an
2079 explanation from agency staff as to the regulations and
2080 requirements that were applied to claimant's case in making the
2081 decision.

2082 (x) After the hearing, the hearing officer will
2083 prepare a written summary of the hearing procedure and file it
2084 with the case record. The hearing officer will consider the facts
2085 presented at the local hearing in reaching a decision. The
2086 claimant will be notified of the local hearing decision on the
2087 appropriate form that will state clearly the reason for the
2088 decision, the policy that governs the decision, the claimant's
2089 right to appeal the decision to the state office, and, if the
2090 original adverse action is upheld, the new effective date of the
2091 reduction or termination of benefits or services if continuation
2092 of benefits applied during the hearing process. The new effective
2093 date of the reduction or termination of benefits or services must
2094 be at the end of the fifteen-day advance notice period from the
2095 mailing date of the notice of hearing decision. The notice to
2096 claimant will be made part of the case record.

2097 (xi) The claimant has the right to appeal a local
2098 hearing decision by requesting a state hearing in writing within
2099 fifteen (15) days of the mailing date of the notice of local
2100 hearing decision. The state hearing request should be made to the
2101 regional office. If benefits have been continued pending the
2102 local hearing process, then benefits will continue throughout the
2103 fifteen-day advance notice period for an adverse local hearing
2104 decision. If a state hearing is timely requested within the



2105 fifteen-day period, then benefits will continue pending the state
2106 hearing process. State hearings requested after the fifteen-day
2107 local hearing advance notice period will not be accepted unless
2108 the initial thirty-day period for filing a hearing request has not
2109 expired because the local hearing was held early, in which case a
2110 state hearing request will be accepted as timely within the number
2111 of days remaining of the unexpired initial thirty-day period in
2112 addition to the fifteen-day time period. Continuation of benefits
2113 during the state hearing process, however, will only apply if the
2114 state hearing request is received within the fifteen-day advance
2115 notice period.

2116 (xii) When a request for a state hearing is
2117 received in the regional office, the request will be made part of
2118 the case record and the regional office will prepare the case
2119 record and forward it to the appropriate division in the state
2120 office within five (5) days of receipt of the state hearing
2121 request. A request for a state hearing received in the state
2122 office will be forwarded to the regional office for inclusion in
2123 the case record and the regional office will prepare the case
2124 record and forward it to the appropriate division in the state
2125 office within five (5) days of receipt of the state hearing
2126 request.

2127 (xiii) Upon receipt of the hearing record, an
2128 impartial hearing officer will be assigned to hear the case either
2129 by the Executive Director of the Division of Medicaid or his or
2130 her designee. Hearing officers will be individuals with
2131 appropriate expertise employed by the division and who have not
2132 been involved in any way with the action or decision on appeal in
2133 the case. The hearing officer will review the case record and if
2134 the review shows that an error was made in the action of the
2135 agency or in the interpretation of policy, or that a change of
2136 policy has been made, the hearing officer will discuss these
2137 matters with the appropriate agency personnel and request that an



2138 appropriate adjustment be made. Appropriate agency personnel will
2139 discuss the matter with the claimant and if the claimant is
2140 agreeable to the adjustment of the claim, then agency personnel
2141 will request in writing dismissal of the hearing and the reason
2142 therefor, to be placed in the case record. If the hearing is to
2143 go forward, it shall be scheduled by the hearing officer in the
2144 manner set forth in subparagraph (iii) of this paragraph (e).

2145 (xiv) In conducting the hearing, the state hearing
2146 officer will inform those present of the following:

2147 (A) That the hearing will be recorded on tape
2148 and that a transcript of the proceedings will be typed for the
2149 record;

2150 (B) The action taken by the agency which
2151 prompted the appeal;

2152 (C) An explanation of the claimant's rights
2153 during the hearing as outlined in subparagraph (vi) of this
2154 paragraph (e);

2155 (D) That the purpose of the hearing is for
2156 the claimant to express dissatisfaction and present additional
2157 information or evidence;

2158 (E) That the case record is available for
2159 review by the claimant or representative during the hearing;

2160 (F) That the final hearing decision will be
2161 rendered by the Executive Director of the Division of Medicaid on
2162 the basis of facts presented at the hearing and the case record
2163 and that the claimant will be notified by letter of the final
2164 decision.

2165 (xv) During the hearing, the claimant and/or
2166 representative will be allowed an opportunity to make a full
2167 statement concerning the appeal and will be assisted, if
2168 necessary, in disclosing all information on which the claim is
2169 based. All persons representing the claimant and those
2170 representing the Division of Medicaid will have the opportunity to



2171 state all facts pertinent to the appeal. The hearing officer may
2172 recess or continue the hearing for a reasonable time should
2173 additional information or facts be required or if some change in
2174 the claimant's circumstances occurs during the hearing process
2175 which impacts the appeal. When all information has been
2176 presented, the hearing officer will close the hearing and stop the
2177 recorder.

2178 (xvi) Immediately following the hearing the
2179 hearing tape will be transcribed and a copy of the transcription
2180 forwarded to the regional office for filing in the case record.
2181 As soon as possible, the hearing officer shall review the evidence
2182 and record of the proceedings, testimony, exhibits, and other
2183 supporting documents, prepare a written summary of the facts as
2184 the hearing officer finds them, and prepare a written
2185 recommendation of action to be taken by the agency, citing
2186 appropriate policy and regulations that govern the recommendation.
2187 The decision cannot be based on any material, oral or written, not
2188 available to the claimant before or during the hearing. The
2189 hearing officer's recommendation will become part of the case
2190 record which will be submitted to the Executive Director of the
2191 Division of Medicaid for further review and decision.

2192 (xvii) The Executive Director of the Division of
2193 Medicaid, upon review of the recommendation, proceedings and the
2194 record, may sustain the recommendation of the hearing officer,
2195 reject the same, or remand the matter to the hearing officer to
2196 take additional testimony and evidence, in which case, the hearing
2197 officer thereafter shall submit to the executive director a new
2198 recommendation. The executive director shall prepare a written
2199 decision summarizing the facts and identifying policies and
2200 regulations that support the decision, which shall be mailed to
2201 the claimant and the representative, with a copy to the regional
2202 office if appropriate, as soon as possible after submission of a
2203 recommendation by the hearing officer. The decision notice will



2204 specify any action to be taken by the agency, specify any revised
2205 eligibility dates or, if continuation of benefits applies, will
2206 notify the claimant of the new effective date of reduction or
2207 termination of benefits or services, which will be fifteen (15)
2208 days from the mailing date of the notice of decision. The
2209 decision rendered by the Executive Director of the Division of
2210 Medicaid is final and binding. The claimant is entitled to seek
2211 judicial review in a court of proper jurisdiction.

2212 (xviii) The Division of Medicaid must take final
2213 administrative action on a hearing, whether state or local, within
2214 ninety (90) days from the date of the initial request for a
2215 hearing.

2216 (xix) A group hearing may be held for a number of
2217 claimants under the following circumstances:

2218 (A) The Division of Medicaid may consolidate
2219 the cases and conduct a single group hearing when the only issue
2220 involved is one (1) of a single law or agency policy;

2221 (B) The claimants may request a group hearing
2222 when there is one (1) issue of agency policy common to all of
2223 them.

2224 In all group hearings, whether initiated by the Division of
2225 Medicaid or by the claimants, the policies governing fair hearings
2226 must be followed. Each claimant in a group hearing must be
2227 permitted to present his or her own case and be represented by his
2228 or her own representative, or to withdraw from the group hearing
2229 and have his or her appeal heard individually. As in individual
2230 hearings, the hearing will be conducted only on the issue being
2231 appealed, and each claimant will be expected to keep individual
2232 testimony within a reasonable time frame as a matter of
2233 consideration to the other claimants involved.

2234 (xx) Any specific matter necessitating an
2235 administrative hearing not otherwise provided under this article
2236 or agency policy shall be afforded under the hearing procedures as



2237 outlined above. If the specific time frames of such a unique
2238 matter relating to requesting, granting, and concluding of the
2239 hearing is contrary to the time frames as set out in the hearing
2240 procedures above, the specific time frames will govern over the
2241 time frames as set out within these procedures.

2242 (4) The Executive Director of the Division of Medicaid, with
2243 the approval of the Governor, shall be authorized to employ
2244 eligibility, technical, clerical and supportive staff as may be
2245 required in carrying out and fully implementing the determination
2246 of Medicaid eligibility, including conducting quality control
2247 reviews and the investigation of the improper receipt of medical
2248 assistance. Staffing needs will be set forth in the annual
2249 appropriation act for the division. Additional office space as
2250 needed in performing eligibility, quality control and
2251 investigative functions shall be obtained by the division.

2252 **SECTION 13.** Section 43-13-117.1, Mississippi Code of 1972,
2253 is brought forward as follows:

2254 43-13-117.1. It is the intent of the Legislature to expand
2255 access to Medicaid-funded home- and community-based services for
2256 eligible nursing facility residents who choose those services.
2257 The Executive Director of the Division of Medicaid is authorized
2258 to transfer funds allocated for nursing facility services for
2259 eligible residents to cover the cost of services available through
2260 the Independent Living Waiver, the Traumatic Brain Injury/Spinal
2261 Cord Injury Waiver, the Elderly and Disabled Waiver, and the
2262 Assisted Living Waiver programs when eligible residents choose
2263 those community services. The amount of funding transferred by
2264 the division shall be sufficient to cover the cost of home- and
2265 community-based waiver services for each eligible nursing facility
2266 resident who chooses those services. The number of nursing
2267 facility residents who return to the community and home- and
2268 community-based waiver services shall not count against the total
2269 number of waiver slots for which the Legislature appropriates



2270 funding each year. Any funds remaining in the program when a
2271 former nursing facility resident ceases to participate in a home-
2272 and community-based waiver program under this provision shall be
2273 returned to nursing facility funding.

2274 **SECTION 14.** Section 43-13-117.2, Mississippi Code of 1972,
2275 is brought forward as follows:

2276 43-13-117.2. The Division of Medicaid is authorized and
2277 directed to study the feasibility of implementing a pilot program
2278 to provide chronic disease management of chronic obstructive
2279 pulmonary disease (COPD) using private sources of funding in an
2280 effort to reduce the financial and clinical burden of COPD illness
2281 upon the Medicaid program and the citizens of Mississippi. If a
2282 pilot program is deemed feasible, such a program shall be
2283 implemented and a report of findings and recommendations be
2284 prepared and provided to the Office of the Governor and the
2285 Chairmen of the House and Senate Public Health and Welfare
2286 Committees and the Chairman of the House Medicaid Committee in
2287 order to evaluate the effectiveness of the pilot program in
2288 reducing costs within the Medicaid program and in providing
2289 improved health and well-being of the affected patients.

2290 **SECTION 15.** Section 43-13-117.3, Mississippi Code of 1972,
2291 is brought forward as follows:

2292 43-13-117.3. The Division of Medicaid, in consultation with
2293 the State Department of Health and the State Department of
2294 Rehabilitation Services, is authorized and directed to study the
2295 feasibility of implementing a pilot program to provide bariatric
2296 surgery in the morbidly obese as a treatment option in an effort
2297 to reduce the financial and clinical burden of morbid obesity upon
2298 the Medicaid program and the citizens of Mississippi. If a pilot
2299 program is deemed feasible, such a program shall be implemented
2300 and a report of findings and recommendations be prepared and
2301 provided to the Office of the Governor and the Chairmen of the
2302 House and Senate Public Health and Welfare Committees and the



2303 Chairman of the House Medicaid Committee in order to evaluate the
2304 effectiveness of the pilot program.

2305 **SECTION 16.** Section 43-13-118, Mississippi Code of 1972, is
2306 brought forward as follows:

2307 43-13-118. It shall be the duty of each provider
2308 participating in the medical assistance program to keep and
2309 maintain books, documents, and other records as prescribed by the
2310 division of Medicaid in substantiation of its claim for services
2311 rendered Medicaid recipients, and such books, documents, and other
2312 records shall be kept and maintained for a period of five (5)
2313 years or for whatever longer period as may be required or
2314 prescribed under federal or state statutes and shall be subject to
2315 audit by the division. The division shall be entitled to full
2316 recoupment of the amount it has paid any provider of medical
2317 service who has failed to keep or maintain records as required
2318 herein.

2319 **SECTION 17.** Section 43-13-120, Mississippi Code of 1972, is
2320 brought forward as follows:

2321 43-13-120. (1) Any person who is a Medicaid recipient and
2322 is receiving medical assistance for services provided in a
2323 long-term care facility under the provisions of Section 43-13-117
2324 from the Division of Medicaid in the Office of the Governor, who
2325 dies intestate and leaves no known heirs, shall have deemed,
2326 through his acceptance of such medical assistance, the Division of
2327 Medicaid as his beneficiary to all such funds in an amount not to
2328 exceed Two Hundred Fifty Dollars (\$250.00) which are in his
2329 possession at the time of his death. Such funds, together with
2330 any accrued interest thereon, shall be reported by the long-term
2331 care facility to the State Treasurer in the manner provided in
2332 subsection (2).

2333 (2) The report of such funds shall be verified, shall be on
2334 a form prescribed or approved by the Treasurer, and shall include
2335 (a) the name of the deceased person and his last known address



2336 prior to entering the long-term care facility; (b) the name and
2337 last known address of each person who may possess an interest in
2338 such funds; and (c) any other information which the Treasurer
2339 prescribes by regulation as necessary for the administration of
2340 this section. The report shall be filed with the Treasurer prior
2341 to November 1 of each year in which the long-term care facility
2342 has provided services to a person or persons having funds to which
2343 this section applies.

2344 (3) Within one hundred twenty (120) days from November 1 of
2345 each year in which a report is made pursuant to subsection (2),
2346 the Treasurer shall cause notice to be published in a newspaper
2347 having general circulation in the county of this state in which is
2348 located the last known address of the person or persons named in
2349 the report who may possess an interest in such funds, or if no
2350 such person is named in the report, in the county in which is
2351 located the last known address of the deceased person prior to
2352 entering the long-term care facility. If no address is given in
2353 the report or if the address is outside of this state, the notice
2354 shall be published in a newspaper having general circulation in
2355 the county in which the facility is located. The notice shall
2356 contain (a) the name of the deceased person; (b) his last known
2357 address prior to entering the facility; (c) the name and last
2358 known address of each person named in the report who may possess
2359 an interest in such funds; and (d) a statement that any person
2360 possessing an interest in such funds must make a claim therefor to
2361 the Treasurer within ninety (90) days after such publication date
2362 or the funds will become the property of the State of Mississippi.
2363 In any year in which the Treasurer publishes a notice of abandoned
2364 property under Section 89-12-27, the Treasurer may combine the
2365 notice required by this section with the notice of abandoned
2366 property. The cost to the Treasurer of publishing the notice
2367 required by this section shall be paid by the Division of
2368 Medicaid.



2369 (4) Each long-term care facility that makes a report of
2370 funds of a deceased person under this section shall pay over and
2371 deliver such funds, together with any accrued interest thereon, to
2372 the Treasurer not later than ten (10) days after notice of such
2373 funds has been published by the Treasurer as provided in
2374 subsection (3). If a claim to such funds is not made by any
2375 person having an interest therein within ninety (90) days of the
2376 published notice, the Treasurer shall place such funds in the
2377 special account in the State Treasury to the credit of the
2378 "Governor's Office - Division of Medicaid" to be expended by the
2379 Division of Medicaid for the purposes provided under Mississippi
2380 Medicaid Law.

2381 (5) This section shall not be applicable to any Medicaid
2382 patient in a long-term care facility of a state institution listed
2383 in Section 41-7-73, who has a personal deposit fund as provided
2384 for in Section 41-7-90.

2385 **SECTION 18.** Section 43-13-121, Mississippi Code of 1972, is
2386 brought forward as follows:

2387 43-13-121. (1) The division shall administer the Medicaid
2388 program under the provisions of this article, and may do the
2389 following:

2390 (a) Adopt and promulgate reasonable rules, regulations
2391 and standards, with approval of the Governor, and in accordance
2392 with the Administrative Procedures Law, Section 25-43-1 et seq.:

2393 (i) Establishing methods and procedures as may be
2394 necessary for the proper and efficient administration of this
2395 article;

2396 (ii) Providing Medicaid to all qualified
2397 recipients under the provisions of this article as the division
2398 may determine and within the limits of appropriated funds;

2399 (iii) Establishing reasonable fees, charges and
2400 rates for medical services and drugs; in doing so, the division
2401 shall fix all of those fees, charges and rates at the minimum



2402 levels absolutely necessary to provide the medical assistance
2403 authorized by this article, and shall not change any of those
2404 fees, charges or rates except as may be authorized in Section
2405 43-13-117;

2406 (iv) Providing for fair and impartial hearings;

2407 (v) Providing safeguards for preserving the
2408 confidentiality of records; and

2409 (vi) For detecting and processing fraudulent
2410 practices and abuses of the program;

2411 (b) Receive and expend state, federal and other funds
2412 in accordance with court judgments or settlements and agreements
2413 between the State of Mississippi and the federal government, the
2414 rules and regulations promulgated by the division, with the
2415 approval of the Governor, and within the limitations and
2416 restrictions of this article and within the limits of funds
2417 available for that purpose;

2418 (c) Subject to the limits imposed by this article, to
2419 submit a Medicaid plan to the United States Department of Health
2420 and Human Services for approval under the provisions of the
2421 federal Social Security Act, to act for the state in making
2422 negotiations relative to the submission and approval of that plan,
2423 to make such arrangements, not inconsistent with the law, as may
2424 be required by or under federal law to obtain and retain that
2425 approval and to secure for the state the benefits of the
2426 provisions of that law.

2427 No agreements, specifically including the general plan for
2428 the operation of the Medicaid program in this state, shall be made
2429 by and between the division and the United States Department of
2430 Health and Human Services unless the Attorney General of the State
2431 of Mississippi has reviewed the agreements, specifically including
2432 the operational plan, and has certified in writing to the Governor
2433 and to the executive director of the division that the agreements,



2434 including the plan of operation, have been drawn strictly in
2435 accordance with the terms and requirements of this article;

2436 (d) In accordance with the purposes and intent of this
2437 article and in compliance with its provisions, provide for aged
2438 persons otherwise eligible for the benefits provided under Title
2439 XVIII of the federal Social Security Act by expenditure of funds
2440 available for those purposes;

2441 (e) To make reports to the United States Department of
2442 Health and Human Services as from time to time may be required by
2443 that federal department and to the Mississippi Legislature as
2444 provided in this section;

2445 (f) Define and determine the scope, duration and amount
2446 of Medicaid that may be provided in accordance with this article
2447 and establish priorities therefor in conformity with this article;

2448 (g) Cooperate and contract with other state agencies
2449 for the purpose of coordinating Medicaid provided under this
2450 article and eliminating duplication and inefficiency in the
2451 Medicaid program;

2452 (h) Adopt and use an official seal of the division;

2453 (i) Sue in its own name on behalf of the State of
2454 Mississippi and employ legal counsel on a contingency basis with
2455 the approval of the Attorney General;

2456 (j) To recover any and all payments incorrectly made by
2457 the division to a recipient or provider from the recipient or
2458 provider receiving the payments. To recover those payments, the
2459 division may use the following methods, in addition to any other
2460 methods available to the division:

2461 (i) The division shall report to the State Tax
2462 Commission the name of any current or former Medicaid recipient
2463 who has received medical services rendered during a period of
2464 established Medicaid ineligibility and who has not reimbursed the
2465 division for the related medical service payment(s). The State
2466 Tax Commission shall withhold from the state tax refund of the



2467 individual, and pay to the division, the amount of the payment(s)
2468 for medical services rendered to the ineligible individual that
2469 have not been reimbursed to the division for the related medical
2470 service payment(s).

2471 (ii) The division shall report to the State Tax
2472 Commission the name of any Medicaid provider to whom payments were
2473 incorrectly made that the division has not been able to recover by
2474 other methods available to the division. The State Tax Commission
2475 shall withhold from the state tax refund of the provider, and pay
2476 to the division, the amount of the payments that were incorrectly
2477 made to the provider that have not been recovered by other
2478 available methods;

2479 (k) To recover any and all payments by the division
2480 fraudulently obtained by a recipient or provider. Additionally,
2481 if recovery of any payments fraudulently obtained by a recipient
2482 or provider is made in any court, then, upon motion of the
2483 Governor, the judge of the court may award twice the payments
2484 recovered as damages;

2485 (l) Have full, complete and plenary power and authority
2486 to conduct such investigations as it may deem necessary and
2487 requisite of alleged or suspected violations or abuses of the
2488 provisions of this article or of the regulations adopted under
2489 this article, including, but not limited to, fraudulent or
2490 unlawful act or deed by applicants for Medicaid or other benefits,
2491 or payments made to any person, firm or corporation under the
2492 terms, conditions and authority of this article, to suspend or
2493 disqualify any provider of services, applicant or recipient for
2494 gross abuse, fraudulent or unlawful acts for such periods,
2495 including permanently, and under such conditions as the division
2496 deems proper and just, including the imposition of a legal rate of
2497 interest on the amount improperly or incorrectly paid. Recipients
2498 who are found to have misused or abused Medicaid benefits may be
2499 locked into one (1) physician and/or one (1) pharmacy of the



2500 recipient's choice for a reasonable amount of time in order to
2501 educate and promote appropriate use of medical services, in
2502 accordance with federal regulations. If an administrative hearing
2503 becomes necessary, the division may, if the provider does not
2504 succeed in his or her defense, tax the costs of the administrative
2505 hearing, including the costs of the court reporter or stenographer
2506 and transcript, to the provider. The convictions of a recipient
2507 or a provider in a state or federal court for abuse, fraudulent or
2508 unlawful acts under this chapter shall constitute an automatic
2509 disqualification of the recipient or automatic disqualification of
2510 the provider from participation under the Medicaid program.

2511 A conviction, for the purposes of this chapter, shall include
2512 a judgment entered on a plea of nolo contendere or a
2513 nonadjudicated guilty plea and shall have the same force as a
2514 judgment entered pursuant to a guilty plea or a conviction
2515 following trial. A certified copy of the judgment of the court of
2516 competent jurisdiction of the conviction shall constitute prima
2517 facie evidence of the conviction for disqualification purposes;

2518 (m) Establish and provide such methods of
2519 administration as may be necessary for the proper and efficient
2520 operation of the Medicaid program, fully utilizing computer
2521 equipment as may be necessary to oversee and control all current
2522 expenditures for purposes of this article, and to closely monitor
2523 and supervise all recipient payments and vendors rendering
2524 services under this article;

2525 (n) To cooperate and contract with the federal
2526 government for the purpose of providing Medicaid to Vietnamese and
2527 Cambodian refugees, under the provisions of Public Law 94-23 and
2528 Public Law 94-24, including any amendments to those laws, only to
2529 the extent that the Medicaid assistance and the administrative
2530 cost related thereto are one hundred percent (100%) reimbursable
2531 by the federal government. For the purposes of Section 43-13-117,
2532 persons receiving Medicaid under Public Law 94-23 and Public Law



2533 94-24, including any amendments to those laws, shall not be
2534 considered a new group or category of recipient; and

2535 (o) The division shall impose penalties upon Medicaid
2536 only, Title XIX participating long-term care facilities found to
2537 be in noncompliance with division and certification standards in
2538 accordance with federal and state regulations, including interest
2539 at the same rate calculated by the United States Department of
2540 Health and Human Services and/or the Centers for Medicare and
2541 Medicaid Services (CMS) under federal regulations.

2542 (2) The division also shall exercise such additional powers
2543 and perform such other duties as may be conferred upon the
2544 division by act of the Legislature.

2545 (3) The division, and the State Department of Health as the
2546 agency for licensure of health care facilities and certification
2547 and inspection for the Medicaid and/or Medicare programs, shall
2548 contract for or otherwise provide for the consolidation of on-site
2549 inspections of health care facilities that are necessitated by the
2550 respective programs and functions of the division and the
2551 department.

2552 (4) The division and its hearing officers shall have power
2553 to preserve and enforce order during hearings; to issue subpoenas
2554 for, to administer oaths to and to compel the attendance and
2555 testimony of witnesses, or the production of books, papers,
2556 documents and other evidence, or the taking of depositions before
2557 any designated individual competent to administer oaths; to
2558 examine witnesses; and to do all things conformable to law that
2559 may be necessary to enable them effectively to discharge the
2560 duties of their office. In compelling the attendance and
2561 testimony of witnesses, or the production of books, papers,
2562 documents and other evidence, or the taking of depositions, as
2563 authorized by this section, the division or its hearing officers
2564 may designate an individual employed by the division or some other
2565 suitable person to execute and return that process, whose action



2566 in executing and returning that process shall be as lawful as if
2567 done by the sheriff or some other proper officer authorized to
2568 execute and return process in the county where the witness may
2569 reside. In carrying out the investigatory powers under the
2570 provisions of this article, the executive director or other
2571 designated person or persons may examine, obtain, copy or
2572 reproduce the books, papers, documents, medical charts,
2573 prescriptions and other records relating to medical care and
2574 services furnished by the provider to a recipient or designated
2575 recipients of Medicaid services under investigation. In the
2576 absence of the voluntary submission of the books, papers,
2577 documents, medical charts, prescriptions and other records, the
2578 Governor, the executive director, or other designated person may
2579 issue and serve subpoenas instantly upon the provider, his or her
2580 agent, servant or employee for the production of the books,
2581 papers, documents, medical charts, prescriptions or other records
2582 during an audit or investigation of the provider. If any provider
2583 or his or her agent, servant or employee refuses to produce the
2584 records after being duly subpoenaed, the executive director may
2585 certify those facts and institute contempt proceedings in the
2586 manner, time and place as authorized by law for administrative
2587 proceedings. As an additional remedy, the division may recover
2588 all amounts paid to the provider covering the period of the audit
2589 or investigation, inclusive of a legal rate of interest and a
2590 reasonable attorney's fee and costs of court if suit becomes
2591 necessary. Division staff shall have immediate access to the
2592 provider's physical location, facilities, records, documents,
2593 books, and any other records relating to medical care and services
2594 rendered to recipients during regular business hours.

2595 (5) If any person in proceedings before the division
2596 disobeys or resists any lawful order or process, or misbehaves
2597 during a hearing or so near the place thereof as to obstruct the
2598 hearing, or neglects to produce, after having been ordered to do



2599 so, any pertinent book, paper or document, or refuses to appear
2600 after having been subpoenaed, or upon appearing refuses to take
2601 the oath as a witness, or after having taken the oath refuses to
2602 be examined according to law, the executive director shall certify
2603 the facts to any court having jurisdiction in the place in which
2604 it is sitting, and the court shall thereupon, in a summary manner,
2605 hear the evidence as to the acts complained of, and if the
2606 evidence so warrants, punish that person in the same manner and to
2607 the same extent as for a contempt committed before the court, or
2608 commit that person upon the same condition as if the doing of the
2609 forbidden act had occurred with reference to the process of, or in
2610 the presence of, the court.

2611 (6) In suspending or terminating any provider from
2612 participation in the Medicaid program, the division shall preclude
2613 the provider from submitting claims for payment, either personally
2614 or through any clinic, group, corporation or other association to
2615 the division or its fiscal agents for any services or supplies
2616 provided under the Medicaid program except for those services or
2617 supplies provided before the suspension or termination. No
2618 clinic, group, corporation or other association that is a provider
2619 of services shall submit claims for payment to the division or its
2620 fiscal agents for any services or supplies provided by a person
2621 within that organization who has been suspended or terminated from
2622 participation in the Medicaid program except for those services or
2623 supplies provided before the suspension or termination. When this
2624 provision is violated by a provider of services that is a clinic,
2625 group, corporation or other association, the division may suspend
2626 or terminate that organization from participation. Suspension may
2627 be applied by the division to all known affiliates of a provider,
2628 provided that each decision to include an affiliate is made on a
2629 case-by-case basis after giving due regard to all relevant facts
2630 and circumstances. The violation, failure or inadequacy of
2631 performance may be imputed to a person with whom the provider is



2632 affiliated where that conduct was accomplished within the course
2633 of his or her official duty or was effectuated by him or her with
2634 the knowledge or approval of that person.

2635 (7) The division may deny or revoke enrollment in the
2636 Medicaid program to a provider if any of the following are found
2637 to be applicable to the provider, his or her agent, a managing
2638 employee or any person having an ownership interest equal to five
2639 percent (5%) or greater in the provider:

2640 (a) Failure to truthfully or fully disclose any and all
2641 information required, or the concealment of any and all
2642 information required, on a claim, a provider application or a
2643 provider agreement, or the making of a false or misleading
2644 statement to the division relative to the Medicaid program.

2645 (b) Previous or current exclusion, suspension,
2646 termination from or the involuntary withdrawing from participation
2647 in the Medicaid program, any other state's Medicaid program,
2648 Medicare or any other public or private health or health insurance
2649 program. If the division ascertains that a provider has been
2650 convicted of a felony under federal or state law for an offense
2651 that the division determines is detrimental to the best interest
2652 of the program or of Medicaid beneficiaries, the division may
2653 refuse to enter into an agreement with that provider, or may
2654 terminate or refuse to renew an existing agreement.

2655 (c) Conviction under federal or state law of a criminal
2656 offense relating to the delivery of any goods, services or
2657 supplies, including the performance of management or
2658 administrative services relating to the delivery of the goods,
2659 services or supplies, under the Medicaid program, any other
2660 state's Medicaid program, Medicare or any other public or private
2661 health or health insurance program.

2662 (d) Conviction under federal or state law of a criminal
2663 offense relating to the neglect or abuse of a patient in
2664 connection with the delivery of any goods, services or supplies.



2665 (e) Conviction under federal or state law of a criminal
2666 offense relating to the unlawful manufacture, distribution,
2667 prescription or dispensing of a controlled substance.

2668 (f) Conviction under federal or state law of a criminal
2669 offense relating to fraud, theft, embezzlement, breach of
2670 fiduciary responsibility or other financial misconduct.

2671 (g) Conviction under federal or state law of a criminal
2672 offense punishable by imprisonment of a year or more that involves
2673 moral turpitude, or acts against the elderly, children or infirm.

2674 (h) Conviction under federal or state law of a criminal
2675 offense in connection with the interference or obstruction of any
2676 investigation into any criminal offense listed in paragraphs (c)
2677 through (i) of this subsection.

2678 (i) Sanction for a violation of federal or state laws
2679 or rules relative to the Medicaid program, any other state's
2680 Medicaid program, Medicare or any other public health care or
2681 health insurance program.

2682 (j) Revocation of license or certification.

2683 (k) Failure to pay recovery properly assessed or
2684 pursuant to an approved repayment schedule under the Medicaid
2685 program.

2686 (l) Failure to meet any condition of enrollment.

2687 **SECTION 19.** Section 43-13-122, Mississippi Code of 1972, is
2688 brought forward as follows:

2689 43-13-122. (1) The division is authorizeded to apply to the
2690 Center for Medicare and Medicaid Services of the United States
2691 Department of Health and Human Services for waivers and research
2692 and demonstration grants.

2693 (2) The division is further authorized to accept and expend
2694 any grants, donations or contributions from any public or private
2695 organization together with any additional federal matching funds
2696 that may accrue anding, including, but not limited to, one hundred
2697 percent (100%) federal grant funds or funds from any governmental



2698 entity or instrumentality thereof in furthering the purposes and
2699 objectives of the Mississippi Medicaid program, provided that such
2700 receipts and expenditures are reported and otherwise handled in
2701 accordance with the General Fund Stabilization Act. The
2702 Department of Finance and Administration is authorized to transfer
2703 monies to the division from special funds in the State Treasury in
2704 amounts not exceeding the amounts authorized in the appropriation
2705 to the division.

2706 **SECTION 20.** Section 43-13-123, Mississippi Code of 1972, is
2707 brought forward as follows:

2708 43-13-123. The determination of the method of providing
2709 payment of claims under this article shall be made by the
2710 division, with approval of the Governor, which methods may be:

2711 (a) By contract with insurance companies licensed to do
2712 business in the State of Mississippi or with nonprofit hospital
2713 service corporations, medical or dental service corporations,
2714 authorized to do business in Mississippi to underwrite on an
2715 insured premium approach, such medical assistance benefits as may
2716 be available, and any carrier selected under the provisions of
2717 this article is expressly authorized and empowered to undertake
2718 the performance of the requirements of that contract.

2719 (b) By contract with an insurance company licensed to
2720 do business in the State of Mississippi or with nonprofit hospital
2721 service, medical or dental service organizations, or other
2722 organizations including data processing companies, authorized to
2723 do business in Mississippi to act as fiscal agent.

2724 The division shall obtain services to be provided under
2725 either of the above-described provisions in accordance with the
2726 Personal Service Contract Review Board Procurement Regulations.

2727 The authorization of the foregoing methods shall not preclude
2728 other methods of providing payment of claims through direct
2729 operation of the program by the state or its agencies.



2730 **SECTION 21.** Section 43-13-125, Mississippi Code of 1972, is
2731 brought forward as follows:

2732 43-13-125. (1) If Medicaid is provided to a recipient under
2733 this article for injuries, disease or sickness caused under
2734 circumstances creating a cause of action in favor of the recipient
2735 against any person, firm or corporation, then the division shall
2736 be entitled to recover the proceeds that may result from the
2737 exercise of any rights of recovery that the recipient may have
2738 against any such person, firm or corporation to the extent of the
2739 Division of Medicaid's interest on behalf of the recipient. The
2740 recipient shall execute and deliver instruments and papers to do
2741 whatever is necessary to secure those rights and shall do nothing
2742 after Medicaid is provided to prejudice the subrogation rights of
2743 the division. Court orders or agreements for reimbursement of
2744 Medicaid's interest shall direct those payments to the Division of
2745 Medicaid, which shall be authorized to endorse any and all,
2746 including, but not limited to, multi-payee checks, drafts, money
2747 orders, or other negotiable instruments representing Medicaid
2748 payment recoveries that are received. In accordance with Section
2749 43-13-305, endorsement of multi-payee checks, drafts, money orders
2750 or other negotiable instruments by the Division of Medicaid shall
2751 be deemed endorsed by the recipient.

2752 The division, with the approval of the Governor, may
2753 compromise or settle any such claim and execute a release of any
2754 claim it has by virtue of this section.

2755 (2) The acceptance of Medicaid under this article or the
2756 making of a claim under this article shall not affect the right of
2757 a recipient or his or her legal representative to recover
2758 Medicaid's interest as an element of damages in any action at law;
2759 however, a copy of the pleadings shall be certified to the
2760 division at the time of the institution of suit, and proof of
2761 that notice shall be filed of record in that action. The division
2762 may, at any time before the trial on the facts, join in that



2763 action or may intervene in that action. Any amount recovered by a
2764 recipient or his or her legal representative shall be applied as
2765 follows:

2766 (a) The reasonable costs of the collection, including
2767 attorney's fees, as approved and allowed by the court in which
2768 that action is pending, or in case of settlement without suit, by
2769 the legal representative of the division;

2770 (b) The amount of Medicaid's interest on behalf of the
2771 recipient; or such pro rata amount as may be arrived at by the
2772 legal representative of the division and the recipient's attorney,
2773 or as set by the court having jurisdiction; and

2774 (c) Any excess shall be awarded to the recipient.

2775 (3) No compromise of any claim by the recipient or his or
2776 her legal representative shall be binding upon or affect the
2777 rights of the division against the third party unless the
2778 division, with the approval of the Governor, has entered into the
2779 compromise. Any compromise effected by the recipient or his or
2780 her legal representative with the third party in the absence of
2781 advance notification to and approved by the division shall
2782 constitute conclusive evidence of the liability of the third
2783 party, and the division, in litigating its claim against the third
2784 party, shall be required only to prove the amount and correctness
2785 of its claim relating to the injury, disease or sickness. If the
2786 recipient or his or her legal representative fails to notify the
2787 division of the institution of legal proceedings against a third
2788 party for which the division has a cause of action, the facts
2789 relating to negligence and the liability of the third party, if
2790 judgment is rendered for the recipient, shall constitute
2791 conclusive evidence of liability in a subsequent action maintained
2792 by the division and only the amount and correctness of the
2793 division's claim relating to injuries, disease or sickness shall
2794 be tried before the court. The division shall be authorized in



2795 bringing that action against the third party and his or her
2796 insurer jointly or against the insurer alone.

2797 (4) Nothing in this section shall be construed to diminish
2798 or otherwise restrict the subrogation rights of the Division of
2799 Medicaid against a third party for Medicaid provided by the
2800 Division of Medicaid to the recipient as a result of injuries,
2801 disease or sickness caused under circumstances creating a cause of
2802 action in favor of the recipient against such a third party.

2803 (5) Any amounts recovered by the division under this section
2804 shall, by the division, be placed to the credit of the funds
2805 appropriated for benefits under this article proportionate to the
2806 amounts provided by the state and federal governments
2807 respectively.

2808 **SECTION 22.** Section 43-13-126, Mississippi Code of 1972, is
2809 brought forward as follows:

2810 43-13-126. As a condition of doing business in the state,
2811 health insurers, including self-insured plans, group health plans
2812 (as defined in Section 607(1) of the Employee Retirement Income
2813 Security Act of 1974), service benefit plans, managed care
2814 organizations, pharmacy benefit managers, or other parties that
2815 are by statute, contract, or agreement, legally responsible for
2816 payment of a claim for a health care item or service, are required
2817 to:

2818 (a) Provide, with respect to individuals who are
2819 eligible for, or are provided, medical assistance under the state
2820 plan, upon the request of the Division of Medicaid, information to
2821 determine during what period the individual or their spouses or
2822 their dependents may be (or may have been) covered by a health
2823 insurer and the nature of the coverage that is or was provided by
2824 the health insurer (including the name, address and identifying
2825 number of the plan) in a manner prescribed by the Secretary of the
2826 Department of Health and Human Services;



2827 (b) Accept the Division of Medicaid's right of recovery
2828 and the assignment to the division of any right of an individual
2829 or other entity to payment from the party for an item or service
2830 for which payment has been made under the state plan;

2831 (c) Respond to any inquiry by the Division of Medicaid
2832 regarding a claim for payment for any health care item or service
2833 that is submitted not later than three (3) years after the date of
2834 the provision of that health care item or service; and

2835 (d) Agree not to deny a claim submitted by the Division
2836 of Medicaid solely on the basis of the date of submission of the
2837 claim, the type or format of the claim form, or a failure to
2838 present proper documentation at the point of sale that is the
2839 basis of the claim, if:

2840 (i) The claim is submitted by the division within
2841 the three-year period beginning on the date on which the item or
2842 service was furnished; and

2843 (ii) Any action by the division to enforce its
2844 rights with respect to the claim is begun within six (6) years of
2845 the division's submission of the claim.

2846 **SECTION 23.** Section 43-13-127, Mississippi Code of 1972, is
2847 brought forward as follows:

2848 43-13-127. (1) Within sixty (60) days after the end of each
2849 fiscal year and at each regular session of the Legislature, the
2850 division shall make and publish a report to the Governor and to
2851 the Legislature, showing for the period of time covered the
2852 following:

2853 (a) The total number of recipients;

2854 (b) The total amount paid for medical assistance and
2855 care under this article;

2856 (c) The total number of applications;

2857 (d) The number of applications approved;

2858 (e) The number of applications denied;



2859 (f) The amount expended for administration of the
2860 provisions of this article;

2861 (g) The amount of money received from the federal
2862 government, if any;

2863 (h) The amount of money recovered by reason of
2864 collections from third persons by reason of assignment or
2865 subrogation, and the disposition of the same;

2866 (i) The actions and activities of the division in
2867 detecting and investigating suspected or alleged fraudulent
2868 practices, violations and abuses of the program; and

2869 (j) Any recommendations it may have as to expanding,
2870 enlarging, limiting or restricting the eligibility of persons
2871 covered by this article or services provided by this article, to
2872 make more effective the basic purposes of this article; to
2873 eliminate or curtail fraudulent practices and inequities in the
2874 plan or administration thereof; and to continue to participate in
2875 receiving federal funds for the furnishing of medical assistance
2876 under Title XIX of the Social Security Act or other federal law.

2877 (2) In addition to the reports required by subsection (1) of
2878 this section, the division shall submit a report each month to the
2879 Chairmen of the Public Health and Welfare Committees of the Senate
2880 and the House of Representatives and to the Joint Legislative
2881 Budget Committee that contains the information specified in each
2882 paragraph of subsection (1) for the preceding month.

2883 **SECTION 24.** Section 43-13-129, Mississippi Code of 1972, is
2884 brought forward as follows:

2885 43-13-129. Any person making application for benefits under
2886 this article for himself or for another person, and any provider
2887 of services, who knowingly makes a false statement or false
2888 representation or fails to disclose a material fact to obtain or
2889 increase any benefit or payment under this article shall be guilty
2890 of a misdemeanor and, upon conviction thereof, shall be punished
2891 by a fine not to exceed Five Hundred Dollars (\$500.00) or



2892 imprisoned not to exceed one (1) year, or by both such fine and
2893 imprisonment. Each false statement or false representation or
2894 failure to disclose a material fact shall constitute a separate
2895 offense. This section shall not prohibit prosecution under any
2896 other criminal statutes of this state or the United States.

2897 **SECTION 25.** Section 43-13-131, Mississippi Code of 1972, is
2898 brought forward as follows:

2899 43-13-131. Any person who shall, through intentional
2900 misrepresentation, fraud, deceit or unlawful design, either acting
2901 individually or in concert with others, influence any recipient to
2902 elect any particular provider of services, or any particular type
2903 of services, for the purposes and with the intent to obtain or
2904 increase any benefit or payment under this article shall be guilty
2905 of a misdemeanor and, upon conviction thereof, shall be punished
2906 by a fine not exceeding Five Hundred Dollars (\$500.00) or
2907 imprisonment not exceeding one (1) year, or by both such fine and
2908 imprisonment. This section shall not prohibit prosecution under
2909 any other criminal statutes of this state or the United States.

2910 **SECTION 26.** Section 43-13-133, Mississippi Code of 1972, is
2911 brought forward as follows:

2912 43-13-133. It is the intent of the Legislature that all
2913 federal matching funds for medical assistance under Titles V,
2914 XVIII and XIX of the federal Social Security Act paid into any
2915 state health agency after the passage of this article shall be
2916 used exclusively to defray the cost of medical assistance expended
2917 under the terms of this article.

2918 **SECTION 27.** Section 43-13-137, Mississippi Code of 1972, is
2919 brought forward as follows:

2920 43-13-137. The division is an agency as defined under
2921 Section 25-43-3 and, therefore, must comply in all respects with
2922 the Administrative Procedures Law, Section 25-43-1 et seq.

2923 **SECTION 28.** Section 43-13-139, Mississippi Code of 1972, is
2924 brought forward as follows:



2925 43-13-139. Nothing contained in this article shall be
2926 construed to prevent the Governor, in his discretion, from
2927 discontinuing or limiting medical assistance to any individuals
2928 who are classified or deemed to be within any optional group or
2929 optional category of recipients as prescribed under Title XIX of
2930 the federal Social Security Act or the implementing federal
2931 regulations. If the Congress or the United States Department of
2932 Health and Human Services ceases to provide federal matching funds
2933 for any group or category of recipients or any type of care and
2934 services, the division shall cease state funding for such group or
2935 category or such type of care and services, notwithstanding any
2936 provision of this article.

2937 **SECTION 29.** Section 43-13-213, Mississippi Code of 1972, is
2938 brought forward as follows:

2939 43-13-213. A person shall not make, present or cause to be
2940 made or presented a claim for Medicaid benefits, knowing the claim
2941 to be false, fictitious or fraudulent.

2942 **SECTION 30.** Section 43-13-223, Mississippi Code of 1972, is
2943 brought forward as follows:

2944 43-13-223. (1) An action brought in connection with any
2945 matter under this article may be filed in the circuit court of the
2946 First Judicial District of Hinds County or in the circuit court of
2947 the county in which the defendant resides, and may be prosecuted
2948 to final judgment in satisfaction there.

2949 (2) Process issued by a court in which an action is filed
2950 may be served anywhere in the state.

2951 **SECTION 31.** This act shall take effect and be in force from
2952 and after its passage.

