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GENERAL PROVISIONS
HISTORY & LEGAL BASE

A. PROGRAM DESCRIPTION

Title XIX of the Social Security Act, enacted in 1965, provides authority for states to establish Medicaid programs to provide medical assistance to needy individuals. The program is jointly financed by the Federal and State governments and administered by States. Within broad Federal rules, each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures. Payments for services are made directly by the State to the providers that furnish the services.

B. BACKGROUND

Enabling legislation for the Medicaid program in Mississippi was enacted during a special session of the legislature in l969. Funds were appropriated and the Mississippi Medicaid Commission was designated as the single state agency to administer the program. State statutes governing Medicaid may be found in Sections 43-l3-l0l et. seq. of the Mississippi Code of l972.

From l969 to l973, the determination of Medicaid eligibility was the responsibility of the State Department of Public Welfare (DPW). During this time period, DPW authorized money payments for the aged, blind and disabled and dependent children.

C. SSI PROGRAM

The passage of Public Law 92-603 amended Title XVI of the Social Security Act and established the Supplemental Security Income (SSI) Program for the aged, blind and disabled. State statutes were amended to specify that DPW would no longer determine eligibility for a monthly payment for the aged, blind and disabled.

P.L. 92-603 allowed States an option to either grant Medicaid to all persons receiving SSI (known as Section l634) or to grant Medicaid to persons who met more restrictive criteria set by States (known as 209-b). The Mississippi Legislature voted to limit Medicaid eligibility to persons who met more restrictive criteria and to designate the DPW as the certifying agency for Medicaid.

D. 1634 AGREEMENT

During the l980 Session of the Mississippi Legislature, Senate Bill 2ll8 changed the Medicaid eligibility criteria to l634 status whereby Medicaid would be granted to all individuals receiving SSI. In addition, SSI criteria would be used to determine eligibility for all aged, blind and disabled individuals. During the l98l Legislative Session, Senate Bill 2478 authorized the Mississippi Medicaid Commission to make its own Medicaid determination for aged, blind and disabled individuals.

E. CURRENT STRUCTURE

Senate Bill 3050 entitled the "Mississippi Administrative Reorganization Act of l984" transferred the powers and responsibilities of the Mississippi Medicaid Commission to the Division of Medicaid in the Office of the Governor. Thus, the Division of Medicaid is currently the single State agency designated to administer the Medicaid Program.

GENERAL PROVISIONS
COVERAGE GROUPS

A. DIVISION OF MEDICAID

The duties of the Medicaid agency were set out by enabling legislation and include:

-- To set regulations and standards for the administration of the Medicaid program

-- To receive and expend funds for the program

-- To submit a State Plan for Medicaid in accordance with Federal regulations

-- To make the necessary reports to the State and Federal governments

-- To define and determine the scope, duration, and amount of Medicaid coverage

-- To cooperate and contract with other state agencies for the purpose of conducting the Medicaid program

-- To bring suit in its own name

-- To recover payments incorrectly made to or by recipients or providers

-- To investigate alleged or suspected violations or abuses of the Medicaid program

-- To establish and provide methods of administration for the operation of the Medicaid program

-- To contract with the Federal government to provide Medicaid to certain refugees

-- To determine eligibility for Medicaid for categorically needy families, children, pregnant women, aged, blind and disabled coverage groups

-- To provide Medicaid Quality Control for Medicaid only recipients

-- To provide the opportunity for children to apply for CHIP

B. DEPARTMENT OF HUMAN SERVICES (DHS)

The duties of the staff of DHS (formerly Department of Public Welfare/DPW) with regard to Medicaid includes:

-- To provide the opportunity for persons to apply for Medicaid benefits through all foster care and refugee programs.

-- To determine eligibility for foster children and adoption assistance related Medicaid applicants and certify them as eligible, notify them of ineligibility, and determine retroactive eligibility when appropriate.

-- To redetermine foster care and adoption assistance Medicaid eligibility at the required intervals.

-- To provide the opportunity for filing appeals and to conduct the hearings for eligibility certifications that DHS certifies.

-- To provide Medicaid Quality Control for foster care and adoption assistance recipients.

-- To identify and report third party resources for foster care and adoption assistance recipients.

GENERAL PROVISIONS
COVERAGE GROUPS

A. INTRODUCTION

Title XIX of the Social Security Act provides authority for states to establish Medicaid programs to provide medical assistance to needy individuals. Section 1902(a)(10) of the Act describes the group of individuals to whom medical assistance may be provided under two broad classifications: The categorically needy and the medically needy.

1. Categorically Needy

This group consists of:

a. mandatory categorically needy - Includes needy individuals who are receiving, or are deemed to be receiving, cash payments under cash assistance programs (AFDC, SSI, title IV-E). Generally, states must cover all mandatory groups.

b. optional categorical needy - Includes needy individuals who share financial and categorical (age, blindness, disability, for example) requirements with cash assistance recipients but states may cover these groups at their option.

2. Medically Needy

Includes individuals who meet the nonfinancial eligibility requirements of the cash assistance programs but who have income/resources that exceed allowable levels. Individuals with excess income may become Medicaid eligible if they incur medical expenses equal to the amount by which their income exceeds a medically needy level. This process is called "spending down."

Coverage of this group is also at states' option. Mississippi does not cover this optional classification of eligibles.

B. MANDATORY COVERAGE OF FAMILIES AND CHILDREN

The following groups of eligibles are handled by the Division of Medicaid unless otherwise noted. Applications are filed at the Medicaid Regional Office that serves the county where the individual lives.

These coverage groups that Mississippi is required to cover under federal law and are referred to as Mandatory Categorically Needy coverage groups:

1. Pre-reform AFDC Eligibles (42 CFR 435.110, Sec. 1931 and 1902(a)(10)(A)(i)(I) of the Act

The Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193) eliminated the AFDC Program and replaced it with a block grant program for Temporary Assistance for Needy Families (TANF). Mississippi implemented the TANF Program effective October 1, 1996.

The PRWOA of 1996 (welfare reform law) established a new Medicaid eligibility group for low income families with children which is referred to as the Pre-reform AFDC category of eligibles or Section 1931 eligibles as this is the newly created section of the Social Security Act describing pre-reform AFDC eligibility.

All references to AFDC or title IV-A are references to AFDC under the AFDC State Plan in effect on July 16, 1996.

Individuals deemed to be receiving AFDC:

a. an assistance unit is deemed to be Medicaid eligible for four (4) calendar months because of increased child support that terminates the pre-reform AFDC eligibility (42 CFR 435.115).

b. families terminated from pre-reform AFDC due to increased earnings receive up to 12 months of extended Medicaid effective 04-01-90 (P.L. 100-485, Family Support Act of 1988, Section 1925 of the Act).

c. individuals who are ineligible for pre-reform AFDC because of requirements that do not apply under title XIX of the Act (42 CFR 435.113).

2. **COL Eligibles (42 CFR 435.114)**

Individuals who would be eligible for AFDC except for the increase in Social Security benefits effective July 1, 2972.

3. **Qualified Pregnant Women and Children (42 CFR 435.116)**

a. a pregnant woman who would be eligible for AFDC if the child were born and living with her; or

b. a pregnant woman in an intact family (or pregnant female eligible as a minor child in an intact family) who meets the income and resource requirements of the AFDC program

4. **Newborn Children (42 CFR 435.117)**

Effective 07-0l-85, newborn children born on or after 10-01-84 are covered by Medicaid if the mother is eligible for and receiving Medicaid when the child is eligible for and receiving Medicaid when the child is born. Effective 01-01-91, the child is eligible from birth and remains eligible for one (l) year as long as the mother remains eligible or would remain eligible if pregnant and the child remains in the same household as the mother. (P.L. 101-508, OBRA 1990).

5. **Postpartum Eligibility Mothers (42 CFR 435.170)**

A woman who, while pregnant, is eligible for and applies and qualifies for Medicaid continues to be eligible for all pregnancy related and postpartum medical assistance for sixty (60) days after the pregnancy ends.

6.	**IV-E Foster Care and Adoption Assistance (42 CFR 435.145)**	Children under age 18 for whom an adoption assistance agreement under Title IV-E is in effect and children who receive Title IV-E foster care maintenance payments. Effective 07/01/01, continuous Medicaid coverage is granted to foster care adolescents from age 18 to 21 who leave DHS foster care. **The Department of Human Services determines eligibility for all IV-E children.**
7.	**Expanded Medicaid-133% FPL (P.L. 100-360, OBRA 1989)**	Effective 07/01/90, pregnant women and children under age 6 whose income does not meet or exceed 133% of the federal poverty level.
8.	**Poverty Level Medicaid (P.L. 101-508, OBRA 1990)**	Effective 07/01/91, pregnant women and children born after 09/30/83 whose age does not exceed 19 years are covered if family income does not exceed 100% of the federal poverty level.

C. **OPTIONAL COVERAGE OF FAMILIES AND CHILDREN**

These are coverage groups that Mississippi has chosen, at option, to cover for families and children. They are referred to as Optional Categorically Needy:

1. **CWS Foster Care Children (42 CFR 435.227)**

Foster children under age 21 in custody of DHS and children receiving State subsidized adoption payments.

Effective 07/01/01, continuous Medicaid coverage is granted to foster care children who leave foster care at or after age 18 until they turn 21 years of age.

The Department of Human Services determines eligibility for foster children who are placed in licensed foster care living arrangements who have income below established guidelines. Foster children who do not meet DHS eligibility guidelines may qualify for coverage through other appropriate Medicaid programs certified by the Division of Medicaid or through the SSI Program.

2. **185% FPL (P.L. 100-203, OBRA 1987)**

Effective 10/01/88, pregnant women and children up to age 1 are covered provided income does not exceed 185% of the federal poverty level.

3. **Children's Health Insurance Program (CHIP) (P.L. 105-33, BBA of 1997)**

The Balanced Budget Act of 1997 amended the Social Security Act to add a new Title XXI, State Children's Health Insurance Program, for the purpose of expanding child health assistance to uninsured, low income children. In Mississippi, the first or transitional phase of CHIP extended Medicaid coverage to all children under age 19 whose family income did not exceed 100% of the federal poverty limit effective 07/01/98.

Effective 01/01/00, uninsured children whose family income does not exceed 200% of the federal poverty limit can qualify for separate health insurance coverage through the Children's Health Insurance Program (CHIP). Coverage is effective either the month following application or the following month, depending on the date of disposition of the application.

4.	**Family Planning Waiver (Section 1115 of The Social Security Act)**	Women of child bearing age defined as ages 13-44 may qualify for family planning services only if income does not exceed 185% of the federal poverty level and the woman does not otherwise qualify for full Medicaid. Certain conditions apply. The State Department of Health administers the program.

D. MANDATORY COVERAGE OF THE AGED, BLIND AND DISABLED

The following groups of the aged, blind and disabled are handled by the Social Security Administration through the Supplemental Security Income (SSI) Program. Applications for SSI are filed with the local Social Security Office that Serves the county where the individual lives.

1. Individuals Receiving SSI (42 CFR 435.120)

A person is considered to be receiving an SSI payment even if:

a. SSI payments are withheld solely to recover an overpayment or assess a penalty.

b. SSI payments are received under the terms of an agreement to dispose of excess resources.

c. an individual is receiving an emergency advance payment based on presumptive eligibility.

d. an individual is receiving SSI based on presumptive disability.

e. an individual receives payment as a disabled individual under Section 1619(a).

f. disabled or blind individuals who are not eligible for SSI cash payments are considered SSI recipients under Section 1619(b) to receive Medicaid.

g. an individual continues to receive SSI payments while an adverse decision is under appeal.

2. Individuals Receiving Mandatory State Supplement Payments (42 CFR 435.130)

In order to protect aged, blind and disabled cash assistance recipients who were converted to SSI beneficiaries as of 01/74 from suffering a loss of income under income under the SSI Program, Congress passed P.L. 93-66 in 07/73 requiring all States to furnish supplementary payments to certain recipients The purpose of the mandatory payment is to ensure that no individual or couple who received, or was eligible to receive, assistance in one of the adult categories in 12/73 will have lower income under SSI in 01/74 and in subsequent months.

This payment is certified by the State DHS and is paid by the SSA. The payment amount is reflected on the SDX provided by SSA and is shown as the "State Amount."

Currently there are no remaining state supplement cases.

E. MANDATORY COVERAGE OF THE AGED, BLIND AND DISABLED

These are coverage groups that Mississippi is required to cover under federal law and are referred to as Mandatory Categorically Needy coverage groups. These groups are certified by the Division of Medicaid. Applications are filed at the Medicaid Regional Office that serves the county where the individual or medical facility is located.

1. **Grand-fathered Eligibles (42 CFR 435.132)**

Institutionalized individuals who were eligible in December 1973 provided they remain institutionalized and remain eligible under December 1973 financial criteria.

2. **HR-1 Eligibles (42 CFR 435.134)**

Individuals who would be eligible for SSI except for the increase in Social Security in July 1972.

3. **COL Eligibles (42 CFR 435.135)**

Current recipients of Title II (Social Security) benefits who after April 1977 were entitled to and received both Title II and received benefits and who lost SSI eligibility, but who would still be eligible for SSI if the Title II cost-of-living increase(s) received by the individual and his/her financially responsible spouse since the individual was last eligible for and achieved SSI and Title II concurrently, were deducted from countable income.

4. **COBRA Widow(er)s (42 CFR 435.137)**

Disabled widow/widowers who lost SSI benefits due to changes in the computation of their 1983 Social Security disability benefits.

5. **DAC Eligibles (P.L.99-643 Employment Opportunities for Disabled Americans Act)**

Disabled adult children who become ineligible for SSI after July 1, 1987 because of entitlement to, or an increase in, Title II disabled adult child (DAC) benefits.

6.	**OBRA-87 Widow(er)s (42 CFR 435.138)**	Effective 07-01-88, individuals age 60-65 who are eligible for Social Security Widow(er) Insurance benefits, who have not become eligible for Medicare, and who are ineligible for SSI benefits because of the receipt of Social Security benefits.
7.	**OBRA-90 Widow(er)s (P.L. 101-508 OBRA 1990)**	Effective 01-01-91, individuals who lose SSI because of receipt of Social Security benefits resulting from the change in definition of disability for widow(er)s provided they are not entitled to Medicare, Part A.
8.	**QMB's (P.L. 100-360 Medicare Catastrophic Coverage Act of 1988)**	Effective 07-01-89, Qualified Medicare Beneficiaries (QMB's) who are entitled to Medicare, Part A, and have income that does not exceed the federal poverty level. QMB's are eligible for Medicare cost-sharing expenses only unless the individual also qualifies for coverage under another Medicaid eligibility group.
9.	**QWDI'S (P.L. 101-239 OBRA 1989)**	Effective 07-01-90, Qualified Working Disabled individuals are eligible for payment of Medicare Part A premiums only provided income does not exceed 200% of the federal poverty level and disability insurance benefits under Title II ended due to earnings.
10.	**SLMB's (P.L. 101-508 OBRA 1990)**	Effective 01-01-93, Specified Low-Income Medicare Beneficiaries (SLMB's), are eligible for payment of Medicare Part B premiums only provided income does not exceed 110% of the federal poverty level and the individual is eligible for Medicare Part A. Effective 01-01-95, the income limit increased to 120% of the poverty level.

11. Qualifying Individuals (P.L. 105-33 Balanced Budget Act of 1997)

Effective 01-01-98, Qualifying Individuals with income above 120% of the Federal Poverty Level (FPL) but less than 135% of the FPL are known as QI-1's. Medicaid benefits are limited to full payment of Medicare Part B premiums. QI-2's are Qualifying Individuals with income of at least 135% of the FPL but not exceeding 175% of the FPL. Medicaid benefits are limited to partial payment of Medicare Part B premiums. Both QI-1 and QI-2 Medicaid benefits are paid from 100% federally capped allocated amounts resulting in benefits available on a first come, first serve basis.

Federal law terminated the QI-1 Program on 12/31/02.

F. OPTIONAL COVERAGE OF THE AGED, BLIND AND DISABLED

These are coverage groups that Mississippi has chosen, at option, to cover for the aged, blind and disabled. They are referred to as Optional Categorically Needy:

1. Long Term Eligible for SSI at Home (42 CFR 435.211)

Individuals who would be eligible for SSI except for their institutional status. These individuals have countable income below the SSI limit for an individual.

2. Long Term Care-Eligible Under 300% Cap (42 CFR 435.236)

Individuals in institutions who are eligible under a special income level who remain institutionalized for thirty (30) consecutive days or longer. The special income limit is equal to 300% of the SSI limit for an individual. Individuals with income in excess of this limit may qualify under specific trust provisions.

3. Disabled Children Living At-Home (42 CFR 435.225)

Effective 07/01/89, Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid Medicaid if in a medical institution and who are receiving medical care at home that would be provided in a medical institution.

4. PLAD Eligibles (P.L. 99-509, SOBRA 1986)

Effective 07/01/89, Poverty Level Aged and Disabled (PLAD) individuals whose income does not exceed 100% of the federal poverty level and whose resources do not exceed the SSI resource limit. Effective July 1, 2000, the income limit was increased to 135% of the poverty level and the resource limit was increased to $4000 for an individual and $4000 for a couple. The PLAD Program was discontinued effective 12/31/05 by State legislation (HB1104).

5. Hospice Eligibles (P.L. 99-272 COBRA 1985)

Effective 04/01/93, individuals who have elected to receive hospice care benefits and who are eligible using the same criteria and special income limit as those in institutions. The hospice care category of eligibility was discontinued effective 05/01/05 by State legislation (HB1104). After 05/01/05, hospice remains a covered Medicaid service only.

6.	**Home & Community Based Waiver Programs (HCBS) (Section 1915(c) of The Social Security Act)**	The Division of Medicaid operates a variety of waiver programs under HCBS programs that are designed as long term care alternative programs. A variety of expanded services are available to qualified participants. Eligibility is determined using the same criteria and special income limit as those in institutions.
7.	**Working Disabled (WD) Eligibles (PL-105-32 BBA-1997)**	Effective 07/01/99, disabled individuals who would be eligible for SSI except for their earned income are eligible for Medicaid if earned income does not exceed 250% of the poverty level. Certain individuals are subject to a premium if earned income is between 150%-250% of the poverty level. The resource limit is $24,000 for an individual and $26,000 for a couple.
8.	**Breast and Cervical Cancer Eligibles (P.L. 106-354 BCCPTA of 2000)**	Effective 07/01/01, women under the age of 65 who have no other creditable health insurance and have been screened and diagnosed to have breast and/or cervical cancer by the Centers for Disease Control and Prevention's Breast and Cervical Cancer Early Detection Program. Income must be under 250% of the federal poverty level. The State Department of Health determines whether a woman meets the qualifying criteria and makes the referral to DOM for coverage.
9.	**Healthier Mississippi Waiver Program (Section 1115**	Effective 01/01/06, individuals who meet the following guidelines may qualify for a limited Medicaid benefit package under the waiver provided: • the individual does not have Medicare coverage or have access to coverage, • the individual is age 65 or over or disabled if under age 65, • income does not exceed 135% of the federal poverty level for an individual or couple,

- resources do not exceed $4,000 for an individual or $6,000 for a couple

- the waiver has an available slot for participation since the waiver has a limit of 5,000 participants in any month.

G. OPTIONAL COVERAGE OF HOME & COMMUNITY BASED SERVICES (HCBS) WAIVER PROGRAM

Section 1915(c) of the Social Security Act permits States to offer, under a waiver of statutory requirements, an array of home and community based services that an individual needs to avoid institutionalization. The following outlines the different HCBS Waiver Programs currently available under Mississippi's Medicaid Program and the coverage groups eligible for participation in each program.

1. HCBS for the Elderly & Disabled

Through Medicaid, the Elderly & Disabled Waiver provides services to individuals who, but for the provision of services would require the level of care provided in a nursing facility. Beneficiaries of this waiver initially had to qualify for Medicaid as Supplemental Security Income (SSI) beneficiaries or meet the income and resource eligibility requirements for Poverty Level Aged and Disabled (PLAD) program. The PLAD coverage group was added to the HCBS Waiver effective July 1, 1999, and discontinued effective 12/31/05. Effective July 1, 2000, beneficiaries of this waiver can have income up to 300% of the SSI Federal Benefit Rate, which is the institutional income limit. Individuals who apply to participate in this waiver must also have deficits in at least three of their activities of daily living.

The waiver services currently available in addition to all regular Medicaid services are:

- case management
- adult day care
- home delivered meals
- institutional respite
- in-home respite care
- homemaker services
- escorted transportation
- extended home health visits

Referrals for the program can be made through the Community Long Term Care Division of DOM or the waiver case managers located at each Area Agency on Aging.

2. **HCBS Waiver for the Physically Handicapped (Independent Living Waiver**

This waiver program is commonly referred to as the Independent Living Waiver. This waiver was created to assist severely orthopedically and neurologically impaired individuals live independently through the services of a personal care attendant. Beneficiaries of this waiver must be able to communicate effectively with the care giver and service provider. There is no age restriction for participation. Participants in this waiver are limited to:

- SSI recipients
- Individuals determined eligible by Medicaid Regional Offices for the Independent Living Waiver that have income up to 300% of the SSI Federal Benefit Rate.

The waiver services currently available in addition to the regular Medicaid services are:

- personal care attendant services
- case management

Referrals for this statewide program may be made through the Community Long Term Care Division of DOM or through the Department of Rehabilitation Services.

3. **HCBS Waiver for the Mentally Retarded/ Developmentally Disabled (MR/DD Waiver)**

The MR/DD Waiver provides services to individuals who, but for the provision of such services, would require the level of care found in an ICF-MR (Intermediate Care Facility for the Mentally Retarded).

Participants in this waiver are limited to those covered under Medicaid as:

- SSI recipients
- Disabled Child Living At Home recipients
- PLAD - Effective 07/01/99
- Effective 07/01/00, beneficiaries of this waiver can have income up to 300% of the SSI Federal Benefit Rate, which is the institutional income limit.

The waiver services currently available in addition to the regular Medicaid services are:

- in-home respite care
- community respite care
- ICF-MR respite care
- residential habilitation
- attendant care aide
- day habilitation
- pre-vocational services
- supported employment
- physical therapy
- occupational therapy
- speech, language & hearing services
- behavioral support & intervention
- specialized medical supplies

Referrals for this statewide program may be made through the Community Long Term Care Division of DOM, the Bureau of Mental Retardation with the Department of Mental Health or the waiver case managers located at each of the Regional ICF-MR's operated by the Department of Mental Health.

4. **Assisted Living Waiver**

Effective 10/01/00, the Assisted Living provides services to individuals who, but for the provision of home and community-based services, would require replacement in a nursing facility. Assisted living services can be provided in licensed personal care homes, community residential care facilities, or in a congregate housing services program that are approved Medicaid providers.

GENERAL PROVISIONS
COVERAGE GROUPS

Participants in this waiver are limited to:

- Individuals 21 years of age or older
- Individuals that must require assistance with at least three activities of daily living, or
- Individuals that have a diagnosis of Alzheimer=s Disease or another type of dementia and require assistance with two or more activities of daily living.
- Beneficiaries of the waiver can have income up to 300% of the SSI Federal Benefit Rate, which is the institutional income limit.

In addition to the regular Medicaid services, the following services are available to eligible beneficiaries.

- case management
- personal care
- homemaker services
- chore services
- attendant care
- medication oversight
- medication administration
- therapeutic social and recreational programming
- intermittent skilled nursing services
- transportation
- attendant call system

This waiver is limited to the following seven counties:

Bolivar	Hinds	Sunflower
Forrest	Lee	
Harrison	Newton	

Referrals for this program may be made through the Community Long Term Care Division of DOM.

5. **Traumatic Brain Injury and Spinal Cord Injury (TBI/SCI)**

This waiver program was created to assist individuals who have a traumatic brain or spinal cord injury, who but for the provisions of this service, would require the level of care provided in a nursing facility.

Effective July 1, 2001, individuals must meet the following criteria:

- Have a diagnosis of a traumatic brain injury or spinal cord injury
- Must be medically stable
- Cannot have an active life threatening condition that would require systematic therapeutic measures, IV drip to control or support blood pressure, intercranial pressure or arterial monitoring

Services offered through the TBI/SCI Waiver include:

- Case management
- In-Home Nursing Respite
- In-Home Companion Respite
- Institutional Respite
- Attendant Care Services
- Environment Accessibility Adaptations
- Specialized Medical Equipment and Supplies

Participants in this waiver age limited to those covered under Medicaid as:

- Low Income Families with Children
- SSI recipients
- Children under age 19
- Foster Care Children
- Disabled Children Living at Home
- 300% FBR income (nursing home limit)

Referrals for this program may be made through the Mississippi Department of Rehabilitation Services.

GENERAL PROVISIONS
MEDICAID SERVICES

A. COVERED SERVICES AND CO-PAYMENTS

The State Medicaid Agency provides the following services to Medicaid recipients on a fiscal year basis (July 1 - June 30). Cost-sharing payments, or co-payments, are specified where applicable. In order to receive the covered benefits described below, an individual must be eligible for full Medicaid coverage. These covered benefits do not apply to individuals eligible for Medicare cost-sharing services only or to individuals eligible in the Healthier Mississippi Waiver or Family Planning Waiver.

1. Inpatient Hospital Care

Up to 30 days of hospital care may be covered annually. Children can get more with a plan of care.

There is a $10.00 co-payment per day.

2. Emergency Room Visits

Up to 6 visits are covered. Children can get more with a plan of care.

There is a $3.00 co-payment per visit unless the visit is a true emergency.

3. Nursing Home Care

Nursing facility care, intermediate care facility services for the Mentally Retarded and psychiatric residential treatment facility care for children under age 21 is provided under Medicaid. Individuals contribute toward the cost of their care based on their monthly income.

4. Physician Visits

Up to 12 visits are covered at a doctor's office or rural health clinic (pre-natal visits do not count against the 12 visit limit). Thirty-six visits are covered for nursing home recipients.

There is a $3.00 co-payment per visit.

5.	**Prescription Drugs**	Up to five (5) prescriptions per month are covered. No more than two (2) of the five may be name brand including refills. Children under 21 may get more with a plan of care. Individuals with Medicare receive their pharmacy benefit through Medicare, Part D. There is a $3.00 co-payment per prescription.
6.	**Laboratory Services**	Lab services are covered when ordered by a doctor and performed by an approved independent laboratory.
7.	**Transportation Services**	Transportation services as medically needed are provided for the recipient's health care, such as ambulance service. There is a $3.00 co-payment per trip. Prior to 05/01/02, the co-payment was $2.00.
8.	**Emergency Dental Extractions**	Emergency Dental Extractions are covered, and if medically necessary, treatment for acute dental conditions (fillings, crowns, bridges and dentures are <u>not</u> covered). There is a $3.00 co-payment per visit.
9.	**Home Health Visits**	Up to 25 visits are covered when ordered by a doctor plus certain medically necessary durable equipment and supplies when furnished by the Home Health Agency or Durable Medical Equipment supplier. There is a $3.00 co-payment per visit.
10.	**Eyeglasses**	One pair of eyeglasses is covered every five (5) years. There is a $3.00 co-payment.
11.	**Hospice**	Hospice services are available for full service Medicaid beneficiaries.

12.	**Child Health Services**	All children and youth under age 21 who are eligible for full Medicaid are eligible for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services. These services include a comprehensive physical and referrals to a doctor for any health problems.
13.	**Limited Coverage for Women Eligible Solely Due to Pregnancy**	Effective September 1, 2002, the Division of Medicaid will not provide eyeglass or dental coverage to women eligible for Medicaid solely because they are pregnant.

B. EXCEPTIONS TO PAYMENTS

The following Medicaid recipients do not pay co-payments:

- Children under 18
- Pregnant women
- Patients in nursing homes
- Patients under family planning

GENERAL PROVISIONS
REGULATIONS SAFEGUARDING CONFIDENTIAL INFORMATION

C. TYPES OF INFORMATION TO BE SAFEGUARDED

The information which shall be considered confidential about applicants and recipients which shall be safeguarded except in the administration of the State Plan shall include:

l. Names and addresses;

2. Medical services provided;

3. Social and economic conditions or circumstances;

4. Agency evaluation of personal information;

5. Medicaid data, including diagnosis and past history of disease or disability.

6. Any information received for verifying income eligibility and amount of medical assistance payments. Income information received from SSA or the Internal Revenue Service must be safeguarded according to the requirements of the agency that furnished the data.

7. Any information received regarding the identification of legally liable third party resources.

D. RELEASE OF INFORMATION

The Medicaid Agency has established criteria specifying the the conditions for release and use of information about applicants and recipients as follows:

l. Information concerning applicants or recipients is subject to disclosure to agencies authorized under Titles IV-A, IV-B, IV-C, IV-D, XX, XVI and other agencies which are Federal or Federally assisted programs which provide assistance, in cash or in-kind, or services, directly to individuals on the basis of need pursuant to appropriately executed data exchange agreements. Access to such information is restricted to those persons or agency representatives who are subject to standards of confidentiality that are comparable to those as set by the Agency.

2. The applicant or recipient or his authorized representative shall have access to certain information in the applicant's or recipient's case record as set out herein below.

3. Information with regard to absent and putative parents in a medical support case may be subject to disclosure for purposes directly connected with obtaining or enforcing medical support.

4. Information necessary in identifying third party liability and for securing recourse against a legally liable third party whether through settlement efforts with the recipient's attorney, insurance carrier, or the legally liable third party may be made available to the recipient, the recipient's attorney, the recipient's insurance carrier, or to providers of services for the recipient. Any other release for TPL purposes should be cleared through the Legal Unit.

5. Information shall be provided to county and district attorneys or the U. S. prosecuting attorney or the Medicaid Fraud Control Unit of the Attorney General's Office in conducting or assisting in an investigation, prosecution, or civil or criminal proceedings relating to abuse, suspected fraud, or the fraudulent receipt of Medicaid, and in connection with the location of non-supporting parents, the establishment of paternity, and the obtaining of medical support.

6. Information provided to an outside source in matters not relating to the administration of the State Plan, upon the execution of written consent for the release of such information. If, because of an emergency situation, time does not permit obtaining written consent before release, the Agency will notify the family or individual immediately after supplying the information.

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E. OTHER INFORMATION TO BE DISCLOSED

The Medicaid Agency is required under Federal and State requirements to publish regularly statistical data about the Medicaid Program. State and Regional staff are authorized to release and to interpret the following information:

l. The number of recipients, the total amount paid for Medicaid services, the total number of applications, the total number of applicants approved, the total number of applications denied, and similar data, compiled monthly, quarterly, or annually.

2. Services available from the Medicaid Agency and the conditions under which the services can be reimbursed, medical support activities and information concerning the collection and distribution of records summarized.

F. DISCLOSURE TO ASSISTANCE AGENCIES

Agencies which have standards of confidentiality comparable to those of Medicaid and which provide assistance or services applicants and recipients, and with whom information is exchanged for the purpose of the administration of the Medicaid Program are:

l. Department of Human Services

2. The Medicaid Agency's fiscal agent

3. Division of Vocational Rehabilitation, State Department of Education

4. The Social Security Administration and its District Offices

5. The Mississippi State Department of Health and their County Health Offices (only if they are a provider of medical services for which the information is requested).

6. State Department of Mental Health and the Regional Mental Health Centers (only if they are a provider of medical services for which the information is requested).

7. State Mental Hospitals and general hospitals, the Social Service Department and the reimbursement offices for providers (only as to services each provider rendered to a specific Medicaid recipient).

8. Veterans Administration (only if they are a provider of services and then only for those recipients for whom they provided the service or to confirm benefits).

Generally, the list of names of applicants or recipients shall not be released to these or other agencies, except as specified, but the release of information shall be on request from the agency and the purpose must reasonably relate to the function of the Agency's programs and to the function of the agency requesting the information. When an agency makes a request for information which that agency normally would be ascertaining for itself and which is not in behalf of applicant or recipient, the request will be denied.

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G. PUBLIC AGENCIES WITH WHOM LISTS ARE EXCHANGED

Formal arrangements have been made for the Agency to supply a printed list of names and addresses or specific information to other public agencies as follows:

l. To the State Department of Human Services and its county offices, to the Disability Determination Services, and to the Vocational Rehabilitation Division of the State Department of Education.

2. Data information exchanged between the Agency, its fiscal agent, State Department of Human Services, the Social Security Administration, including, without limitation through the inclusion, new case cycle data for AFDC, monthly AFDC case data, quarterly reconciliation information, enumeration data, Buy-In data, Bendex data, and SDX data.

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H. DISCLOSURE TO APPLICANT, RECIPIENT OR REPRESENTATIVE

An applicant's or recipient's case record is available for examination by the applicant or recipient or his duly authorized representative in the following situations:

l. In connection with a request for a hearing as otherwise provided in the regulations relating to administrative hearings. Refer to Section J, Hearings, "Rights of the Claimant".

2. Information as to the receipt of amounts of Medicaid received by a recipient when requested by a person filing a Federal or State income tax return and when authorized, in writing, by the recipient. Release of information to the Internal Revenue Service shall be granted only upon a signed authorization of the recipient.

3. Information supplied by the applicant or recipient or obtained by the worker that the applicant or recipient needs in order to be able to qualify for benefits which he has requested. This includes medical reports, as the examining physician must release this information to his patient. It includes proof of age, documents relating to real and personal property, and other factual material that will assist an applicant or recipient in obtaining a service or a benefit.

4. The applicant's or recipient's statement of income and resources and other forms which the applicant or recipient has signed which are contained in the case record.

5. Budgets worked to determine eligibility for programs for which the department is responsible.

6. Any case information when the applicant or recipient presents a written request which specifies the material desired and the purpose for which the material will be used.

When the request is made by a person other than the applicant or recipient, the information will not be made available without the applicant's or recipient's written permission prior to releasing the information. The written statement will be made a permanent part of the case record. The Regional Office will advance the information from the case record or provide copies of the material requested.

I. DISCLOSURE TO PROSECUTING ATTORNEYS

The county or district prosecuting attorneys or the U. S. prosecuting attorneys shall have access to information from the case records for the following purposes:

l. Making an audit or investigation of an alleged violation of the provisions contained in the State or Federal statutes or regulations touching on abuse, fraud, or suspected fraud in the receipt of Medicaid.

2. The locating of deserting or putative parents, establishing paternity, and securing medical support.

When acting in the official capacity in behalf of the Agency, the county and district attorneys or the U. S. prosecuting attorneys are authorized to review without written request, case record material in the case record of the individual involved and other material relating to the individual's case, such as medical assistance records, computer printouts, medical support, fiscal and bookkeeping records.

Before releasing any case record information to a county, district or U. S. prosecuting attorney, contact the Legal Unit of the Division of Medicaid for official clearance in releasing case record material.

J. COURT SUBPOENAS

Any and all court subpoenas for a case record or for any agency representative to testify concerning an applicant or recipient must be issued in the name of the Executive Director of the Division of Medicaid and routed to the Director's office immediately upon receipt. The Regional Office will be notified of appropriate action to take.

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K. PERSONS AUTHORIZED TO DISCLOSE INFORMATION

Disclosure of all information, including records of every kind, should be governed by these regulations:

The release of information upon request, unless previously authorized by the Mississippi Medicaid Agency, can be authorized by:

l. The Director of the Mississippi Medicaid Agency or the Deputy Director in his absence the Director's absence.

2. The Regional Office Supervisor, if the information is contained in the Regional Office records.