
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 1969. 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 43-13-101 et. seq. of the Mississippi Code of 1972.

From 1969 to 1973, 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 1634) 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.

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D. 1634 AGREEMENT

During the 1980 Session of the Mississippi Legislature, Senate Bill 2118 changed the Medicaid eligibility criteria to 1634 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 1981 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 1984" 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.

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**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 aged, blind, and disabled coverage groups
- to provide Medicaid Quality Control for AFDC-related Medicaid only recipients and SSI-related aged, blind and disabled recipients

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AGENCY RESPONSIBILITIES

**B. DEPARTMENT OF
HUMAN SERVICES
(DHS)**

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

- to provide the opportunity for persons to apply for Medicaid benefits through all AFDC-related Medicaid programs for families and children, including refugee programs.
- to determine eligibility of AFDC-related Medicaid applicants and certify them as eligible, to notify them of ineligibility, to determine retroactive eligibility when appropriate.
- to redetermine AFDC-related Medicaid assistance eligibility at the required intervals.
- to provide the opportunity for filing appeals and to conduct the hearings.
- to furnish information to the Division of Medicaid on persons included in AFDC budgets who are eligible for medical services and for use in the payment of the Buy-in for Part B of the Medicare program.
- to identify cases of improper payment made to AFDC recipients and report these to the Division of Medicaid.
- to provide information and referral services on Early and Periodic Screening, Diagnosis and Treatment.
- to provide Medicaid Quality Control for AFDC-cash assistance recipients.
- to provide information on family planning services.
- to identify and report third party resources for AFDC recipients.
- to provide referral for Social Services.

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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.

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**B. MANDATORY
COVERAGE OF
FAMILIES
AND CHILDREN**

The following groups of eligibles are handled by the State Department of Human Services (DHS). Applications are filed at the county offices of DHS.

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

**I. 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.

Since the TANF Program requirements mirrors the pre-reform AFDC requirements in Mississippi, TANF recipients receive Medicaid with no separate application required. Individuals who do not receive TANF cash assistance but who are eligible using pre-reform AFDC criteria are eligible for Medicaid-only.

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).

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- 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, 1972.
- 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; or
 - c. a child under age 8 who meets the income and resource requirements of the AFDC program
- 4. **Newborn Children**
(42 CFR 435.117) Effective 07-01-85, 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 (1) 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.

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| 6. | IV-E Adoption Assistance
(42 CFR 435.145) | <p>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.</p> <p>Effective 07/01/01, continuous Medicaid coverage is granted to foster care adolescents from age 18 to 21 who leave DHS foster care.</p> |
| 7. | Expanded Medicaid-133% FPL
(P.L. 100-360, OBRA 1989) | <p>Effective 07/01/90, pregnant women and children under age 6 whose income does not meet or exceed 133% of the federal poverty level.</p> |
| 8. | Poverty Level Medicaid
(P.L. 101-508, OBRA 1990) | <p>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.</p> |

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- 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. Ribicoff Children (42 CFR 435.222)**

Children under 18 and born before 09/30/83 who meet the income and resource requirements of AFDC, but do not qualify as dependent children. (Children born after 9/30/83 are mandatory eligibles.)
 - 2. 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.
 - 3. 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.
 - 4. 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 will extend Medicaid coverage to all children under age 19 whose family income does not exceed 100% of the federal poverty limit effective 07/01/98. This will accelerate the phase in of children ages 15-19. (Children born after 09/30/83 whose family income does not exceed the poverty level are mandatory eligibles.)

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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 Childrens 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.

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**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.

**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 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.

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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."

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**E. MANDATORY
COVERAGE OF
THE AGED, BLIND
AND DISABLED AS
MAO**

The following groups of eligibles are handled by the Division of Medicaid, Office of the Governor, as Medical Assistance Only (MAO) cases. Applications are filed at the Medicaid Regional Office which serves the county where the individual and/or medical facility is located.

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

- 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.

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- 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, and whose resources do not exceed twice the SSI resource limits. 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, resources do not exceed twice the SSI resource limits 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, resources do not exceed twice the SSI resource limits and the individual is eligible for Medicare Part A. Effective 01-01-95, the income limit increased to 120% of the poverty level.

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- 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.

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- 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 their institutional status.
 - 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.
 - 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 individuals whose income does not exceed the federal poverty level and whose resources do not exceed the SSI resource limit.
 - 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.

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| 6. | HCBS Waiver for the Physically Handicapped (Section 1915(c) of Social Security Act) | Effective 07/01/93, individuals who meet the qualifications for participation in the Home & Community Based Services Waiver for the Physically Handicapped. 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. |
| 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 for breast and 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. |

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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.
- 1. Inpatient Hospital Care**

Up to 30 days of hospital care may be covered annually; however, before any recipient will be allowed more than 15 days in any one year, prior approval must be obtained from the Division of Medicaid. Infants under the age of one year are allowed unlimited days in a disproportionate share hospital as defined by the Division of Medicaid.

There is a \$10.00 co-payment per day. Prior to 05/01/02, the co-payment was \$5.00.
 - 2. Emergency Room Visits**

Up to 6 visits are covered.

There is a \$3.00 co-payment per visit unless the visit is a true emergency. Prior to 05/01/02, the co-payment was \$2.00.
 - 3. Nursing Home Care**

Skilled, Intermediate Care and Intermediate Care for the Mentally Retarded is provided.
 - 4. Physician Visits**

Up to 12 visits are covered at a doctor's office, rural health clinic or hospital emergency room (pre-natal visits do not count against the 12-day limit). 36 visits are covered for nursing home recipients.

There is a \$3.00 co-payment per visit. Prior to 05/01/02, the co-payment was \$1.00.
 - 5. Prescription Drugs**

Effective 06/01/02, up to seven (7) per month are covered if the drugs are on Medicaid's formulary. Prior approval is required after five (5) prescriptions per month. Effective 11/01/00 through 05/31/02, no prior approval was required for 10 prescriptions per month.

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- There is a \$1.00 co-payment per prescription for generic drugs and \$3.00 per prescription for brand name drugs. Prior to 05/01/02, the co-payment was \$1.00 for all drugs.
- 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 condition (fillings, crowns, bridges and dentures are not covered).
- There is a \$3.00 co-payment per visit. Prior to 05/01/02, the co-payment was \$2.00.
- 9. Home Health Visits** Up to 50 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. Prior to 05/01/02, the co-payment was \$2.00.
- 10. Eyeglasses** One pair of eyeglasses is covered if needed because of eye surgery.
- Effective 05/01/02, the Division of Medicaid will reimburse for one pair of eyeglasses for adults every three (3) years. Corrective lens must be prescribed by an ophthalmologist or optometrist. This benefit is in addition to eyeglasses that are prescribed following eye surgery.

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Effective 05/01/02, the Division of Medicaid will reimburse for one pair of eyeglasses for adults every five (5) years. The Division of Medicaid will reimburse for one (1) pair of eyeglasses for children each year. Any additional medically necessary eyeglasses for children within the year will require prior authorization. Corrective lens must be prescribed by an ophthalmologist or optometrist. This benefit is in addition to eyeglasses that are prescribed following eye surgery.

Effective 07/01/00 through 04/30/02, the Division of Medicaid reimbursed for one pair of eyeglasses for adults every three years.

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.

There is a \$3.00 co-payment. Prior to 05/01/02, the co-payment was \$2.00.

11. Child Health Services

All children and youth under age 21 who are on 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.

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REGULATIONS SAFEGUARDING CONFIDENTIAL INFORMATION

**A. LEGAL BASE &
PURPOSE**

Title XIX, Section 1902(a)(7), of the Federal Social Security Act requires that the Mississippi Medicaid Agency's State Plan provide safeguards which restrict the use or disclosure of information concerning applicants or recipients of Medicaid to purposes directly connected with the administration of the Plan (Medicaid). The Federal Regulations, 42 CFR 431.300, specifies the State Plan requirements, the types of information to be safeguarded, the conditions for release of safeguarded information, and the restriction on the distribution of other information.

Section 43-13-121(3) of the Mississippi Code of 1972 authorized and empowered the Agency to provide safeguards for preserving the confidentiality of records.

**B. ADMINISTRATION
OF THE PROGRAM -
DEFINITION**

For purposes of complying with the Federal and State laws and program regulations, "administration of the program" encompasses those administrative activities and responsibilities which the Agency is required to engage in to ensure effective program operation. Such activities include determining eligibility and methods of reimbursement, processing claims, conducting fair hearings, arranging for inter-agency agreements, ensuring the availability of transportation, conducting outreach, screening, and other similar activities.

Additionally, administration of the Program includes conducting or assisting in investigation, prosecution, or civil or criminal proceedings deemed to be related to the administration of the Plan.

Also, identifying potential third party liability and seeking recourse against legally liable third parties constitute purposes directly related to the administration of the State Plan.

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**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:

1. 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 conditions for release and use of information about applicants and recipients as follows:

1. 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.

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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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REGULATIONS SAFEGUARDING CONFIDENTIAL INFORMATION

**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:

1. 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:

1. 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).

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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:

1. 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:

1. 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.

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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:

1. 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:

1. 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.