Title 23: Division of Medicaid

Part 300: Appeals

Chapter 2: Beneficiary Right to Appeal and Fair Hearing

Rule 2.4: Types of Hearings

A. The applicant or beneficiary, or their representative may request to present an appeal through a local hearing, a state hearing, or both.

B. There are two instances in which a local hearing is not permitted, and the applicant or beneficiary must request relief directly through a state hearing. These are:

1. A disability or blindness denial, or termination, or

2. A level of care denial or termination for an applicant or beneficiary in the Katie Beckett category of eligibility.

C. Local and/or state level hearings will be held by telephone unless, at the discretion of the hearing officer, it is determined that an in-person hearing is necessary.

Source: 42 C.F.R. Part 431 Subpart E; Miss. Code Ann. §§ 43-13-116, 43-13-117, 43-13-121.

History: Revised eff. 07/01/2025; Revised eff. 03/01/2023; New Rule moved from Miss. Admin. Code Part 100 eff. 07/01/2020.

Rule 2.17: State Hearing Requests for Appeals that Must Originate as a State Hearing

A. Disability or Blindness Denials.

1. An appeal related to a disability or blindness denial must be resolved through a state hearing. Procedures for filing a state hearing appeal are detailed in Rules 2.5 through 2.8 of this chapter and should be followed.

2. After the state hearing, the hearing officer will forward all medical information to the Disability Determination Service (DDS) for reconsideration. A review team consisting of medical staff who were not involved in any way with the original decision will review the medical information and hearing transcript and give a decision on the disability or blindness factor.

3. The DDS decision is final and binding on the Division of Medicaid.

B. Level of Care Denials or Terminations for an applicant or beneficiary in the Katie Beckett category of eligibility.

1. An appeal related to level of care denials or terminations for the Katie Beckett category of

eligibility must be resolved through a state hearing. Procedures for filing a state hearing appeal are detailed in Rules 2.5 through 2.8 of this chapter and should be followed.

2. The final decision of the hearing officer must be based on oral and written evidence, testimony, exhibits and other supporting documents that were discussed at the hearing. The decision cannot be based on any material, oral or written, not available to and discussed with the beneficiary/applicant or representative.

3. Following the hearing, the hearing officer will make a written recommendation of the decision to be rendered as a result of the hearing. The recommendation, which becomes part of the state hearing record, will cite the appropriate rule that governs the recommendation.

4. The Executive Director of the Division of Medicaid, upon review of the recommendation, proceedings and the record, may:

   a) Sustain the recommendation of the hearing officer,

   b) Reject the recommendation,

   c) Remand the matter to the hearing officer for additional testimony and evidence, in which case the hearing officer will submit a new recommendation to the Executive Director after the additional action has been taken, or

   d) Amend the recommendation and adopt the remainder.

5. The decision letter will specify any action to be taken by the agency and any revised eligibility dates. If the decision is adverse and continuation of benefits is applicable, the applicant/beneficiary or representative will be notified of the new effective date of reduction or termination of benefits or services, which will be fifteen (15) days from the date of the notice of decision.

6. The decision of the Executive Director of the Division of Medicaid is final and binding. The applicant/beneficiary is entitled to seek judicial review in a court of appropriate jurisdiction.

7. Should the applicant/beneficiary file an appeal of an issue that has already been adjudicated without a change in circumstances or agency rule, the appeal will be dismissed as untimely, and the applicant/beneficiary will be notified in writing by the office to which the appeal was made (be it the Regional Office or the Central Office) explaining that the appeal cannot be honored. If the applicant/beneficiary's circumstances or agency rule have changed, the applicant/beneficiary will be advised to file a new application.

Source: 42 C.F.R. Part 431 Subpart E; Miss. Code Ann. §§ 43-13-116, 43-13-117, 43-13-121.

History: Revised eff. 07/01/2025; Renamed and revised eff. 03/01/2023; New Rule moved from Miss. Admin. Code Part 100 eff. 08/01/2020.

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2. A level of care denial or termination for an applicant or beneficiary in the Katie Beckett category of eligibility ~~Disabled Child Living at Home~~.

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3. The DDS decision is final and binding on the Division of Medicaid.

B. Level of Care Denials or Terminations for an applicant or beneficiary in the Katie Beckett category of eligibility ~~Disabled Child Living at Home (DCLH)~~.

1. An appeal related to level of care denials or terminations for the Katie Beckett category of

eligibility ~~a Disabled Child Living at Home~~ must be resolved through a state hearing. Procedures for filing a state hearing appeal are detailed in Rules 2.5 through 2.8 of this chapter and should be followed.

2. The final decision of the hearing officer must be based on oral and written evidence, testimony, exhibits and other supporting documents that were discussed at the hearing. The decision cannot be based on any material, oral or written, not available to and discussed with the beneficiary/applicant or representative.

3. Following the hearing, the hearing officer will make a written recommendation of the decision to be rendered as a result of the hearing. The recommendation, which becomes part of the state hearing record, will cite the appropriate rule that governs the recommendation.

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7. Should the applicant/beneficiary file an appeal of an issue that has already been adjudicated without a change in circumstances or agency rule, the appeal will be dismissed as untimely, and the applicant/beneficiary will be notified in writing by the office to which the appeal was made (be it the Regional Office or the Central Office) explaining that the appeal cannot be honored. If the applicant/beneficiary's circumstances or agency rule have changed, the applicant/beneficiary will be advised to file a new application.

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