SENATE BILL NO. 2188

AN ACT TO AMEND SECTIONS 35-1-21 AND 35-1-27, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT THE STATE VETERANS AFFAIRS BOARD SHALL CONTRACT WITH THE UNIVERSITY MEDICAL CENTER FOR THE OPERATION OF THE STATE VETERANS HOMES, TO AUTHORIZE THE UNIVERSITY MEDICAL CENTER TO ESTABLISH VETERANS HOME RESIDENT RETIREMENT AND PERSONAL DEPOSIT FUND ACCOUNTS FOR THE PAYMENT OF CARE AT THE VETERANS HOMES AND TO PROVIDE THAT THE FUNDS IN SUCH ACCOUNTS SHALL BE MATCHED WITH FEDERAL FUNDS AND UTILIZED TO PROVIDE SERVICES FOR THE VETERANS HOME RESIDENTS UNDER THE MEDICAID PROGRAM; TO AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972, TO PROVIDE THAT RESIDENTS IN THE STATES VETERANS HOMES SHALL BE CATEGORICALLY ELIGIBLE FOR BENEFITS UNDER THE MISSISSIPPI MEDICAID PROGRAM; AND FOR RELATED PURPOSES.

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

SECTION 1. Section 35-1-21, Mississippi Code of 1972, is amended as follows:

35-1-21. (1) Upon the establishment of the Mississippi State Veterans Home, and any additional homes as may be established, the Mississippi State Veterans Affairs Board is hereby designated as the governing authority of any such facilities. The operation and maintenance of all veterans homes shall meet the standards of the United States Department of Veterans Affairs with regard to the operation of state veterans homes.

(2) The State Veterans Affairs Board shall contract with the University of Mississippi Medical Center to operate state veterans homes. The mission of the University Medical Center in managing the state veterans homes shall be to provide domiciliary care, medical care and other related services for eligible veterans in the most cost efficient manner. * * * The provisions of this paragraph shall supersede any rule or regulation of the State Personnel Board to the contrary.
(3) The University Medical Center may, as permitted by federal laws or regulations, purchase from the United States Department of Veterans Affairs, from contracts established by the United States Department of Veterans Affairs, or through other sharing agreements between the center and the United States Department of Veterans Affairs, services, commodities, supplies and equipment for use in operation of, and provision of care to residents of, the state veterans homes when such purchases or agreements are advantageous to the veterans and the state.

(4) The Director of the University Medical Center shall have the power to assess and collect charges from residents, residents' estates and from all persons legally liable for the cost of care of such residents in each state veterans home. Such charges may be made against the retirement benefits accruing to the resident. Any funds charged against retirement benefits, or otherwise given or provided for the purpose of paying for care, maintenance or medical needs of such resident shall be deposited by the director or other proper officer of the veterans home to the credit of that resident in an account which shall be known as the Veterans Home Resident Retirement and Personal Deposit Fund Account. The maximum charges which may be made shall be based on the estimated cost of operating the institution, and such costs shall include a reasonable amount for depreciation. The director shall investigate, or cause to be investigated, the financial ability of each patient, his or her estate, and all other persons legally liable for the cost or care of the resident, and the charges assessed shall be in accordance with the ability of the person assessed to pay. The fee shall be adjustable and commensurate with the resident's financial ability to pay. Upon the death or discharge of any resident for whose benefit any such fund has been established, any unexpended balance remaining in his personal deposit fund shall be applied for payment of care, maintenance and medical services. In the event any unexpended balance remains in
that resident's personal deposit fund, and the director or other proper officer has been or shall be unable to locate the person or persons entitled to such unexpended balance, the director or other proper officer may, after the lapse of one (1) year from the date of such death or discharge, deposit the unexpended balance to the credit of that home's operating fund. The aggregate of the amounts in the personal deposit funds of all residents in the state veterans homes shall be used by the University Medical Center to match federal funds to provide authorized services under the Mississippi Medicaid Program for residents of the state veterans homes. * * *

(5) The State Department of Health shall, as appropriate and in its discretion, conduct periodic * * * certification surveys of the state veteran's homes. * * *

SECTION 2. Section 35-1-27, Mississippi Code of 1972, is amended as follows:

35-1-27. The Mississippi Veterans Affairs Board shall determine and set conditions and standards for admission and dismissal of all persons to and from the Mississippi State Veterans Home and such additional homes as may be constructed. In addition, the board shall promulgate such rules and regulations as it deems necessary for the government of the Mississippi State Veterans Home and such additional homes as may be constructed. * * * The establishment of rates for patient care within the patient's ability to pay shall be prescribed by the University of Mississippi Medical Center as provided in Section 35-1-21.

SECTION 3. Section 43-13-115, Mississippi Code of 1972, is amended as follows:

43-13-115. Recipients of medical assistance shall be the following persons only:

(1) Who are qualified for public assistance grants under provisions of Title IV-A and E of the federal Social
Security Act, as amended, as determined by the State Department of Human Services, including those statutorily deemed to be IV-A and low-income families and children under Section 1931 of the Social Security Act as determined by the State Department of Human Services and certified to the Division of Medicaid, but not optional groups except as specifically covered in this section.

For the purposes of this paragraph (1) and paragraphs (8), (17) and (18) of this section, any reference to Title IV-A or to Part A of Title IV of the federal Social Security Act, as amended, or the state plan under Title IV-A or Part A of Title IV, shall be considered as a reference to Title IV-A of the federal Social Security Act, as amended, and the state plan under Title IV-A, including the income and resource standards and methodologies under Title IV-A and the state plan, as they existed on July 16, 1996.

(2) Those qualified for Supplemental Security Income (SSI) benefits under Title XVI of the federal Social Security Act, as amended. The eligibility of individuals covered in this paragraph shall be determined by the Social Security Administration and certified to the Division of Medicaid.

(3) [Deleted]

(4) [Deleted]

(5) A child born on or after October 1, 1984, to a woman eligible for and receiving medical assistance under the state plan on the date of the child’s birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such birth and will remain eligible for such assistance for a period of one (1) year so long as the child is a member of the woman’s household and the woman remains eligible for such assistance or would be eligible for assistance if pregnant. The eligibility of individuals covered in this paragraph shall be determined by the
State Department of Human Services and certified to the Division of Medicaid.

(6) Children certified by the State Department of Human Services to the Division of Medicaid of whom the state and county human services agency has custody and financial responsibility, and children who are in adoptions subsidized in full or part by the Department of Human Services, including special needs children in non-Title IV-E adoption assistance, who are approvable under Title XIX of the Medicaid program.

(7) (a) Persons certified by the Division of Medicaid who are patients in a medical facility (nursing home, hospital, tuberculosis sanatorium or institution for treatment of mental diseases), and who, except for the fact that they are patients in such medical facility, would qualify for grants under Title IV, supplementary security income benefits under Title XVI or state supplements, and those aged, blind and disabled persons who would not be eligible for supplemental security income benefits under Title XVI or state supplements if they were not institutionalized in a medical facility but whose income is below the maximum standard set by the Division of Medicaid, which standard shall not exceed that prescribed by federal regulation;

(b) Individuals who have elected to receive hospice care benefits and who are eligible using the same criteria and special income limits as those in institutions as described in subparagraph (a) of this paragraph (7).

(8) Children under eighteen (18) years of age and pregnant women (including those in intact families) who meet the APDC financial standards of the state plan approved under Title IV-A of the federal Social Security Act, as amended. The eligibility of children covered under this paragraph shall be determined by the State Department of Human Services and certified to the Division of Medicaid.

(9) Individuals who are:
(a) Children born after September 30, 1983, who have not attained the age of nineteen (19), with family income that does not exceed one hundred percent (100%) of the nonfarm official poverty line;

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

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

The eligibility of individuals covered in (a), (b) and (c) of this paragraph shall be determined by the Department of Human Services.

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

(11) Individuals who are sixty-five (65) years of age or older or are disabled as determined under Section 1614(a)(3) of the federal Social Security Act, as amended, and whose income does not exceed one hundred thirty-five percent (135%) of the nonfarm official poverty line as defined by the Office of Management and Budget and revised annually, and whose resources do not exceed those established by the Division of Medicaid.

The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid, and such
individuals determined eligible shall receive the same Medicaid services as other categorical eligible individuals.

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

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

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

(b) Individuals entitled to Part A of Medicare, with income above one hundred twenty percent (120%), but less than one hundred thirty-five percent (135%) of the federal poverty level, and not otherwise eligible for Medicaid. Eligibility for Medicaid benefits is limited to full payment of Medicare Part B premiums. The number of eligible individuals is limited by the availability of the federal capped allocation at one hundred percent (100%) of federal matching funds, as more fully defined in the Balanced Budget Act of 1997.

(c) Individuals entitled to Part A of Medicare, with income of at least one hundred thirty-five percent (135%),
but not exceeding one hundred seventy-five percent (175%) of the federal poverty level, and not otherwise eligible for Medicaid. Eligibility for Medicaid benefits is limited to partial payment of Medicare Part B premiums. The number of eligible individuals is limited by the availability of the federal capped allocation of one hundred percent (100%) federal matching funds, as more fully defined in the Balanced Budget Act of 1997.

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

(14) [Deleted]

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

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

(17) In accordance with the terms of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193), persons who become ineligible for assistance under Title IV-A of the federal Social Security Act, as amended, because of increased income from or hours of employment of the caretaker relative or because of the expiration of the applicable earned income disregards, who were eligible for Medicaid for at least three (3) of the six (6) months preceding...
the month in which such ineligibility begins, shall be eligible
for Medicaid assistance for up to twenty-four (24) months;
however, Medicaid assistance for more than twelve (12) months may
be provided only if a federal waiver is obtained to provide such
assistance for more than twelve (12) months and federal and state
funds are available to provide such assistance.

(18) Persons who become ineligible for assistance under
Title IV-A of the federal Social Security Act, as amended, as a
result, in whole or in part, of the collection or increased
collection of child or spousal support under Title IV-D of the
federal Social Security Act, as amended, who were eligible for
Medicaid for at least three (3) of the six (6) months immediately
preceding the month in which such ineligibility begins, shall be
eligible for Medicaid for an additional four (4) months beginning
with the month in which such ineligibility begins.

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

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

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

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

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

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

The Division of Medicaid shall apply to the United States Secretary of Health and Human Services for a federal waiver of the applicable provisions of Title XIX of the federal Social Security Act, as amended, and any other applicable provisions of federal
law as necessary to allow for the implementation of this paragraph (22). The provisions of this paragraph (22) shall be implemented from and after the date that the Division of Medicaid receives the federal waiver.

The Division of Medicaid shall reapply to the United States Secretary of Health and Human Services for a federal waiver for a demonstration project under authority of this paragraph (22), to allow persons who are workers with a catastrophic illness or injury, as determined by the division, to purchase Medicaid coverage. The term "worker with a catastrophic illness or injury" means a person who is at least sixteen (16) years of age but under sixty-five (65) years of age, who has a physical or mental impairment or injury, including, but not limited to, cancer, that is reasonably expected to cause the person to become disabled as defined under applicable federal law, if the person does not receive services provided by the Medicaid program.

(23) Children certified by the Mississippi Department of Human Services for whom the state and county human services agency has custody and financial responsibility who are in foster care on their eighteenth birthday as reported by the Mississippi Department of Human Services shall be certified Medicaid eligible by the Division of Medicaid until their twenty-first birthday.

(24) Individuals who have not attained age sixty-five (65), are not otherwise covered by creditable coverage as defined in the Public Health Services Act, and have been screened for breast and cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act in accordance with the requirements of that act and who need treatment for breast or cervical cancer. Eligibility of individuals under this paragraph (24) shall be determined by the Division of Medicaid.
(25) Individuals who would be eligible for services in a nursing home but who live in a noninstitutional setting, whose income does not exceed the amount prescribed by federal regulation for nursing home care, and who regularly expend more than fifty percent (50%) of their monthly income on prescription drugs and over-the-counter drugs.

The eligibility of individuals covered under this paragraph (25) shall be determined by the Division of Medicaid. The individuals determined eligible shall be eligible only for prescription drugs and over-the-counter drugs covered under Section 43-13-117(9) and not for any other services covered under Section 43-13-117.

The Division of Medicaid shall apply to the United States Secretary of Health and Human Services for a federal waiver of the applicable provisions of Title XIX of the federal Social Security Act, as amended, and any other applicable provisions of federal law as necessary to allow for the implementation of this paragraph (25). The provisions of this paragraph (25) shall be implemented from and after the date that the Division of Medicaid receives the federal waiver.

(26) Persons who are residents of one of the state's veterans homes. The state's share of funds for providing services to these residents shall be provided from the Resident's Retirement and Personal Deposit funds which shall be administered by the University Medical Center in order to maximize the use of federal Medicaid funds. The Division of Medicaid shall apply for a federal waiver as necessary to allow for the implementation of this paragraph (26).

SECTION 4. This act shall take effect and be in force from and after July 1, 2002.