MISSISSIPPI LEGISLATURE REGULAR SESSION 2024

By: Representatives Johnson, Porter, Clark, Hines

To: Medicaid; Appropriations
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# HOUSE BILL NO. 1146

AN ACT TO BE KNOWN AS THE MISSISSIPPI HEALTH CARE SECURITY AND PROMOTION ACT OF 2024; TO EXPRESS THE INTENT OF THE LEGISLATURE REGARDING EXPANSION OF THE MEDICAID PROGRAM; TO PROVIDE DEFINITIONS FOR THE PURPOSES OF THIS ACT; TO PROVIDE THAT ANY EXPANSION OF THE MEDICAID PROGRAM AND ITS ELIGIBILITY CRITERIA OR COVERED BENEFITS SHALL FALL INTO THE CATEGORIES OUTLINED IN THIS ACT AND BE DEFINED BY THE SECTIONS IN THIS ACT; TO DIRECT THE DIVISION OF MEDICAID TO SUBMIT TO THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) AN APPLICATION FOR A WAIVER OR STATE PLAN AMENDMENT THAT WILL ALLOW THE DIVISION TO EXPAND COVERAGE TO ELIGIBLE INDIVIDUALS WHOSE INCOME IS AT OR BELOW 100% OF THE FEDERAL POVERTY LEVEL; TO DIRECT THE DIVISION TO SUBMIT TO CMS A REQUEST FOR A SECTION 1115 WAIVER THAT WILL ALLOW THE DIVISION TO EXPAND COVERAGE TO ELIGIBLE INDIVIDUALS WHO ARE UNINSURED AND WHOSE INCOME IS NOT LESS THAN 101% OR MORE THAN 200% OF THE FEDERAL POVERTY LEVEL; TO PROVIDE THAT UNINSURED INDIVIDUALS WITH TOTAL HOUSEHOLD INCOME OF NOT LESS THAN 101% OR MORE THAN 200% OF THE FEDERAL POVERTY LEVEL SHALL BE ELIGIBLE FOR EXPANDED COVERAGE THROUGH AN INDIVIDUAL QUALIFIED HEALTH INSURANCE PLAN; TO PROVIDE THAT INDIVIDUALS WITH CURRENT EMPLOYER HEALTH INSURANCE COVERAGE AND UNINSURED INDIVIDUALS WHO ARE OFFERED EMPLOYER HEALTH INSURANCE COVERAGE WITH TOTAL HOUSEHOLD INCOMES OF NOT LESS THAN 101% OR MORE THAN 200% OF THE FEDERAL POVERTY LEVEL SHALL BE ELIGIBLE FOR PREMIUM ASSISTANCE FOR EMPLOYER HEALTH INSURANCE COVERAGE; TO PROVIDE THAT UPON CMS APPROVAL OF REQUESTED WAIVERS OR AMENDMENTS, THE DIVISION SHALL, IN CONJUNCTION AND CONSULTATION WITH RELATED STATE AGENCIES, IMPLEMENT THE APPROVED WAIVER COMPONENTS TO EXPAND ELIGIBILITY CRITERIA FOR THE MEDICAID PROGRAM AS PROVIDED UNDER THE APPLICABLE WAIVER; TO PROVIDE THAT ELIGIBILITY FOR MEDICAID AS DESCRIBED IN THIS ACT SHALL NOT BE DELAYED IF CMS FAILS TO APPROVE ANY REQUESTED WAIVERS OF THE STATE PLAN FOR WHICH THE DIVISION APPLIES, AND SUCH ELIGIBILITY SHALL NOT BE DELAYED WHILE THE DIVISION IS CONSIDERING OR NEGOTIATING ANY WAIVERS TO THE STATE PLAN; TO PROVIDE THAT IF CMS HAS NOT

APPROVED A REQUESTED WAIVER OR STATE PLAN AMENDMENT SUBMITTED BY THE DIVISION ON OR BEFORE DECEMBER 31, 2025, ELIGIBILITY FOR THE MEDICAID PROGRAM SHALL BE EXPANDED TO INCLUDE ALL ELIGIBLE POPULATIONS AND ESSENTIAL HEALTH BENEFITS AS PROVIDED IN THE FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010; TO AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972, TO CONFORM TO THE PRECEDING PROVISIONS; AND FOR RELATED PURPOSES.

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

**SECTION 1. Short title.** This act shall be known and may be cited as the "Mississippi Health Care Security and Promotion Act of 2024."

**SECTION 2. Legislative Intent.** Notwithstanding any general or specific laws to the contrary, it is the intent of the Legislature for the expansion of the Medicaid program to be a fiscally sustainable, cost-effective, impactful, and an opportunity-driven program that:

(a) Expands health insurance coverage opportunities for the population of Mississippians who have not been previously eligible or able to obtain coverage;

(b) Achieves comprehensive and innovative health care reform that builds upon existing Medicaid, private insurance market competition, and value-based insurance purchasing models in providing health insurance coverage to low-income adults in Mississippi;

(c) Reduces the maternal and infant mortality rates in the state through initiatives that promote healthy outcomes for eligible women with high-risk pregnancies;

(d) Promotes the health, welfare, and stability of mothers and their infants before and after delivery;

(e) Strengthens the financial stability of the critical access hospitals and other small, rural hospitals;

(f) Fills gaps in the continuum of care for individuals in target populations in need of services;

(g) Addresses health-related social needs of Mississippians and reduces the additional risk for disease and premature death associated with those needs;

(h) Strengthens the ability of individuals to improve their economic security;

(i) Strengthens the ability of employers to recruit and retain productive employees;

(j) Encourages personal responsibility for individuals to understand their roles and obligations in maintaining private insurance coverage; and

(k) Ensures state responsibility and accountability for the administration of Medicaid health plans.

**SECTION 3. Definitions.** As used in this act, the following terms shall be defined as provided in this section, unless the context requires otherwise:

(a) "CMS" means the federal Centers for Medicare and Medicaid Services.

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

(c) "Eligible individual" means an individual who is in the eligibility category created by Section 1902(a)(10)(A)(i)(VII)

of the Social Security Act, 42 USC Section 1396a(a)(10)(A)(i)(VII).

(d) "Employer health insurance coverage" means a health insurance benefit plan offered by an employer or an employer self-funded insurance plan governed by the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, as amended.

(e) "Health insurance benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, but not including excepted benefits as defined under 42 USC Section 300gg-91(c), as it existed on January 1, 2024.

(f) "Health insurance marketplace" means the applicable entities that were designed to help individuals, families, and businesses in Mississippi shop for and select health insurance plans in a way that permits comparisons of available plans based upon price, benefits, services, and quality.

(g) "Health insurer" means an insurer authorized by the Department of Insurance to provide health insurance or a health insurance benefit plan in the State of Mississippi, including, without limitation:

(i) An insurance company;

(ii) A medical services plan;

(iii) A hospital plan;

(iv) A hospital medical service corporation;

(v) A health maintenance organization;

(vi) A fraternal benefits society;

(vii) Employer health insurance coverage;

(viii) A managed care organization contracted with the Mississippi Coordinated Access Network; and

(ix) Any other entity providing health insurance or a health insurance benefit plan subject to state regulation.

(h) "Health care coverage" means coverage provided through either an individual qualified health insurance plan, a managed care organization, an employer health insurance coverage, the Division of Medicaid's fee-for-service program, or the Division of Medicaid's managed care program.

(i) "Individual qualified health insurance plan" means an individual health insurance benefit plan offered by a health insurer that participates in the health insurance marketplace to provide coverage in Mississippi that covers essential health benefits as defined by the 45 CFR Section 156.110 and any federal insurance regulations, as they existed on January 1, 2024.

**SECTION 4. Medicaid expansion generally.** (1) Any expansion of the Medicaid program and its eligibility criteria or covered benefits shall fall into the categories outlined of this act, and be defined by the sections in this act.

(2) Eligibility criteria for the Medicaid program shall be expanded to cover additional low-income individuals, as defined in Section 5 of this act.

(3) The Division of Medicaid, in coordination with the Mississippi Insurance Department, the State Department of Health, and any other state agencies, as necessary, shall seek approval from CMS to implement the Medicaid waiver expansion program to increase opportunities for low-income individuals to enroll in private or employer sponsored coverage, as defined in Section 6, 7 and 8 of this act.

**SECTION 5. Medicaid program expansion.** (1) The Division of Medicaid shall develop an application for any federal waiver, state plan amendment, or other authority necessary to expand eligibility criteria for the Medicaid programs. Before submitting the application to CMS, the Division of Medicaid shall report the application to the House and Senate Medicaid Committees for review and recommendations. On or before December 31, 2024, the Division of Medicaid shall submit to CMS an application for a waiver or state plan amendment that will, upon approval, allow the division to:

(a) Expand coverage to eligible individuals whose income is at or below one hundred percent (100%) of the federal poverty level;

(b) Obtain maximum federal financial participation under 42 USC Section 1396d(y), as allowed, for enrolling an individual in the Medicaid program;

(c) Provide essential health benefits as defined under 45 CFR Section 156.110 through the state's Medicaid managed care program, the Mississippi Coordinated Access Network;

(d) Provide for twelve (12) months of continuous enrollment that shall not be terminated due to procedural reasons;

(e) Integrate the delivery of physical health services, behavioral health services, and wraparound services with the state's Medicaid managed care program; and

(f) Assist eligible individuals identified as target populations who need a higher level of intervention with wraparound services to improve their health outcomes.

(i) Wraparound services may be determined by the division, in conjunction with the State Department of Health, but shall, at minimum, include:

1. Benefits navigation;

2. Social and community resource navigation;

3. Community health workers.

(2) Upon CMS approval of requested waivers or amendments, the division shall, in conjunction and consultation with related state agencies, implement the approved waiver components to expand eligibility criteria for the Medicaid program through the Mississippi Coordinated Access Network.

(3) If CMS does not approve the initially submitted waiver or amendment, the division shall have ninety (90) days to submit technical corrections or a revised application for approval.

**SECTION 6. Expansion of the eligibility criteria for public health insurance coverage with Section 1115 waiver program.** (1) The Division of Medicaid shall develop an application for any federal waiver, state plan amendment, or other authority necessary to create and establish the Employer Health Insurance Coverage Premium Assistance Program. Before submission of the application to CMS, the Division of Medicaid shall report the application to the House and Senate Medicaid Committees for review and recommendations. On or before December 31, 2024, the Division of Medicaid shall submit to CMS an application for a Section 1115 Waiver that will, upon approval, allow the Division to:

(a) Expand coverage to eligible individuals who are uninsured and whose income is not less than one hundred one percent (101%) or more than two hundred percent (200%) of the federal poverty level;

(b) Prevent further decline in population health outcomes and deterioration of the health care system by:

(i) Reducing improper use of emergency departments;

(ii) Increasing the utilization of primary and preventive health services;

(iii) Increasing the number of preventive health screenings and wellness visits each year;

(iv) Promoting health literacy and proper management of chronic conditions; and

(v) Incentivizing and assisting businesses in providing employer health insurance coverage.

(c) Provide essential health benefits as defined under 45 CFR Section 156.110 through:

(i) An individual qualified health insurance plan; or

(ii) Employer health insurance coverage.

(d) Provide for twelve (12) months of continuous enrollment that shall not be terminated due to procedural reasons;

(e) Obtain maximum federal financial participation under 42 USC Section 1396d(y) or 42 USC Section 1396d(ii), as allowed, for enrolling an individual as a member of the Section 1115 waiver program;

(f) Administer federal funds for assistance in the purchase of private health insurance coverage for newly eligible individuals under the Section 1115 waiver program under this section; and

(g) Demonstrate budget neutrality based on an aggregate dollar cap that cannot exceed the cumulative target.

(3) Upon CMS approval of requested waivers or amendments, the division shall, in conjunction and consultation with related state agencies, implement the waiver program to expand eligibility criteria and covered services of the program.

(4) If CMS does not approve the initially submitted waiver or amendment, the Division shall have ninety (90) days to submit technical corrections or a revised application for approval.

**SECTION 7. Expanded coverage through an individual qualified health plan.** (1) Uninsured individuals with total household incomes of not less than one hundred one percent (101%) or more than two hundred percent (200%) of the federal poverty level shall be eligible for expanded coverage through an individual qualified health insurance plan.

(2) For members enrolled in an individual qualified health insurance plan, the division shall provide for payment of enrollment fees, premiums, deductions, cost sharing or other similar charges on behalf of members, their spouses, and parents, within the limitations of federal law and regulation.

(a) Premium assistance required of the division shall be as follows:

(i) For individuals whose income is not less than one hundred one percent (101%) or more than one hundred fifty percent (150%) of the federal poverty level: the division pays one hundred percent (100%) of the premium.

(ii) For individuals whose income is not less than one hundred fifty-one percent (151%) or more than one hundred seventy-five percent (175%) of the federal poverty level: the division pays seventy-five percent (75%) of the premium.

(iii) For individuals whose income is not less than one hundred seventy-six percent (176%) or more than two hundred percent (200%) of the federal poverty level: the division pays fifty percent (50%) of the premium.

(b) Member contributions to copayments for services provided shall be as follows:

(i) Individuals whose income is not less than one hundred one percent (101%) or more than one hundred thirty-eight percent (138%) of the federal poverty level: no member contributions.

(ii) Individuals whose income is not less than one hundred thirty-nine percent (139%) or more than two hundred percent (200%) of the federal poverty level: an annual maximum of the lesser of Four Hundred Dollars ($400.00) or two percent (2%) of their income.

(c) For the division to provide for such charges, the member shall:

(i) Receive a wellness visit from a qualifying provider in an outpatient setting within one (1) year of enrollment, and on an annual basis for each demonstration year.

1. Failure to meet this requirement shall result in a decrease of no more than fifty percent (50%) in the amount of premium assistance provided by the division.

2. Failure to meet these requirements shall not result in a loss of coverage.

(ii) Subparagraph (i)1 of this paragraph (c) shall not apply to members residing in:

1. Provider Shortage Areas as defined by the United States Department of Health and Human Services, Health Resources and Services Administration; or

2. Medically Underserved Areas as defined by the United States Department of Health and Human Services, Health Resources and Services Administration.

(d) A member that is offered an employer health insurance plan by an employer shall be required to enroll in the employer's health plan.

(3) Annually, the division, in conjunction and consultation with related state agencies, shall develop purchasing guidelines that:

(a) Describe which individual qualified health insurance plans are suitable for purchase in the next demonstration year, including, without limitation:

(i) The level of the plan;

(ii) The amounts of allowable premiums;

(iii) Cost-sharing; and

(iv) Auto-assignment methodology.

(b) Ensure that:

(i) The division shall pay premiums and supplemental cost-sharing reductions directly to an individual qualified health plan;

(ii) Payments to an individual qualified health insurance plan do not exceed budget neutrality limitations in each demonstration year;

(iii) Total payments to all individual qualified health insurance plans combined do not exceed budget targets for the Section 1115 waiver program in each demonstration year;

(iv) Individual qualified health insurance plans meet and report quality and performance measurement targets set by the division; and

(v) At least two (2) health insurers offer individual qualified health insurance plans in each county in the state.

(4) Insurance coverage for a member enrolled in an individual qualified health insurance plan shall be obtained, at a minimum, through silver-level metallic plans as provided in 42 USC Section 18022(d) and Section 18071, as they existed on January 1, 2024, that restrict out-of-pocket costs to amounts that do not exceed applicable out-of-pocket cost limitations.

(5) The Division of Medicaid, State Department of Insurance, and each of the individual qualified health insurance plans shall enter into a memorandum of understanding that shall specify the duties and obligations of each party in the operation of the Section 1115 waiver program at least thirty (30) calendar days before the annual open enrollment period. The memorandums of understanding shall include provisions necessary to effectuate the

purchasing guidelines and reporting requirements including, without limitation, that:

(a) Health insurers shall track the applicable premium payments and cost-sharing collected from the members to ensure that the total amount of an individual's payments for premiums and cost-sharing does not exceed the aggregate cap imposed by 42 CFR Section 447.56;

(b) Health insurers plans maintain a medical-loss ratio of at least eighty percent (80%) as required under 45 CFR Section 158.210(c), as it existed on January 1, 2024, or rebate the difference to the division for those enrolled;

(c) A health insurer that is providing an individual qualified health insurance plan or employer health insurance coverage for a member shall submit claims and enrollment data to the division and Department of Insurance to facilitate such reporting and guidelines; and

(d) A health insurer that is providing an individual qualified health insurance plan or employer health insurance coverage shall make reports to the division and Department of Insurance regarding quality and performance metrics in a manner and frequencies established.

**SECTION 8. Expanded coverage through employer health insurance premium assistance.** (1) Individuals with current employer health insurance coverage and uninsured individuals who are offered employer health insurance coverage with total

household incomes of not less than one hundred one percent (101%) or more than two hundred percent (200%) of the federal poverty level shall be eligible for premium assistance for employer health insurance coverage.

(2) For members with employer health insurance coverage, the division shall provide for payment of enrollment fees, premiums, deductions, cost sharing or other similar charges on behalf of members, their spouses, and parents, within the limitations of federal law and regulation.

(a) Premium assistance required of the division shall be as follows:

(i) For individuals whose income is not less than one hundred one percent (101%) or more than one hundred fifty percent (150%) of the federal poverty level: the division pays one hundred percent (100%) of the premium.

(ii) For individuals whose income is not less than one hundred fifty-one percent (151%) or more than one hundred seventy-five percent (175%) of the federal poverty level: the division pays seventy-five percent (75%) of the premium.

(iii) For individuals whose income is not less than one hundred seventy-six percent (176%) or more than two hundred percent (200%) of the federal poverty level: the division pays fifty percent (50%) of the premium.

(b) Member contributions to copayments for services provided shall be as follows:

(i) Individuals whose income is not less than one hundred one percent (101%) or more than one hundred thirty-eight percent (138%) of the federal poverty level: no member contributions.

(ii) Individuals whose income is not less than one hundred thirty-nine percent (139%) or more than two hundred percent (200%) of the federal poverty level: an annual maximum of the lesser of Four Hundred Dollars ($400.00) or two percent (2%) of their income.

(c) For the division to provide for such charges, the member shall:

(i) Receive a wellness visit from a qualifying provider in an outpatient setting within one (1) year of enrollment, and on an annual basis for each demonstration year.

1. Failure to meet this requirement shall result in a decrease of no more than fifty percent (50%) in the amount of premium assistance provided by the division.

2. Failure to meet these requirements shall not result in a loss of coverage.

(ii) Subparagraph (i)1 of this paragraph (c) shall not apply to members residing in:

1. Provider Shortage Areas as defined by the United States Department of Health and Human Services, Health Resources and Services Administration; or

2. Medically Underserved Areas as defined by the United States Department of Health and Human Services, Health Resources and Services Administration.

(d) The division shall pay premiums and supplemental cost-sharing reductions directly to the employer or insurer.

(3) The division shall provide for a group health insurance plan that businesses not currently offering employer health insurance coverage may opt into.

(4) The division shall ensure that the group health insurance plan being offered is, at minimum, through silver-level metallic plans as provided in 42 USC Section 18022(d) and Section 18071, as they existed on January 1, 2024, that restrict out-of-pocket costs to amounts that do not exceed applicable out-of-pocket cost limitations.

(5) The Division of Medicaid, State Department of Insurance, and each of the employer health insurance plans shall enter into a memorandum of understanding that shall specify the duties and obligations of each party in the operation of the Section 1115 waiver program at least thirty (30) calendar days before the annual open enrollment period. The memorandums of understanding shall include provisions necessary to effectuate the purchasing guidelines and reporting requirements including, without limitation, that:

(a) Health insurers shall track the applicable premium payments and cost-sharing collected from the members to ensure

that the total amount of an individual's payments for premiums and cost-sharing does not exceed the aggregate cap imposed by 42 CFR Section 447.56;

(b) Health insurers plans maintain a medical-loss ratio of at least eighty percent (80%) as required under 45 CFR Section 158.210(c), as it existed on January 1, 2024, or rebate the difference to the division for those enrolled;

(c) A health insurer that is providing an individual qualified health insurance plan or employer health insurance coverage for a member shall submit claims and enrollment data to the division and Department of Insurance to facilitate such reporting and guidelines;

(d) A health insurer that is providing an individual qualified health insurance plan or employer health insurance coverage shall make reports to the division and Department of Insurance regarding quality and performance metrics in a manner and frequencies established.

**SECTION 9. Implementation and enforcement of the act.** (1) Eligibility for Medicaid as described in this act shall not be delayed if CMS fails to approve any requested waivers of the state plan for which the division applies, and such eligibility shall not be delayed while the division is considering or negotiating any waivers to the state plan.

(2) If CMS has not approved a requested waiver or state plan amendment submitted by the division on or before December 31,

2025, eligibility for the Medicaid program shall be expanded to include all eligible populations and essential health benefits as provided in the Federal Patient Protection and Affordable Care Act of 2010, as amended.

(3) If Section 1905(y) of the Social Security Act is held unlawful or unconstitutional by the United States Supreme Court, then the Legislature may declare this act and the sections in this act to be null, void, and of no force and effect.

(4) If federal financial participation for the expanded, newly eligible groups as established in this act is reduced below the ninety percent (90%) commitment described in Section 1905(y) of the Social Security Act, then the Appropriations Committees and Medicaid Committees of the House of Representatives and the Senate, the Public Health and Human Services Committee of the House of Representatives and the Public Health and Welfare Committee of the Senate shall, as soon as practicable, review the effects of such reduction and make a recommendation to the Legislature as to whether Medicaid eligibility expansion provided for in this act should remain in effect.

**SECTION 10.** Section 43-13-115, Mississippi Code of 1972, is amended as follows:

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

(1) Those who are qualified for public assistance grants under provisions of Title IV-A and E of the federal Social

Security Act, as amended, including those statutorily deemed to be IV-A and low income families and children under Section 1931 of the federal Social Security Act. 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. The Department of Human Services shall determine Medicaid eligibility for children receiving public assistance grants under Title IV-E. The division shall determine eligibility for low income families under Section 1931 of the federal Social Security Act and shall redetermine eligibility for those continuing under Title IV-A grants.

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

(3) Qualified pregnant women who would be eligible for Medicaid as a low income family member under Section 1931 of the federal Social Security Act if her child were born. The

eligibility of the individuals covered under this paragraph shall be determined by the division.

(4) [Deleted]

(5) A child born on or after October 1, 1984, to a woman eligible for and receiving Medicaid under the state plan on the date of the child's birth shall be deemed to have applied for Medicaid and to have been found eligible for Medicaid under the plan on the date of that birth, and will remain eligible for Medicaid 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 Medicaid or would be eligible for Medicaid if pregnant. The eligibility of individuals covered in this paragraph shall be determined by 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 departments of human services have 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. The eligibility of the children covered under this paragraph shall be determined by the State Department of Human Services.

(7) 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 that medical facility, would qualify for grants under Title IV, Supplementary Security Income (SSI) benefits under Title XVI or state supplements, and those aged, blind and disabled persons who would not be eligible for Supplemental Security Income (SSI) 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.

(8) Children under eighteen (18) years of age and pregnant women (including those in intact families) who meet the 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 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 level;

(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 division.

(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) Until the end of the day on December 31, 2005, 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 level 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. After December 31, 2005, only those

individuals covered under the 1115(c) Healthier Mississippi waiver will be covered under this category.

Any individual who applied for Medicaid during the period from July 1, 2004, through March 31, 2005, who otherwise would have been eligible for coverage under this paragraph (11) if it had been in effect at the time the individual submitted his or her application and is still eligible for coverage under this paragraph (11) on March 31, 2005, shall be eligible for Medicaid coverage under this paragraph (11) from March 31, 2005, through December 31, 2005. The division shall give priority in processing the applications for those individuals to determine their eligibility under this paragraph (11).

(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 level 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 those 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 level 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.

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 those 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 the ineligibility begins, shall be eligible for Medicaid for up to twelve (12) months. The eligibility of the individuals covered under this paragraph shall be determined by the division.

(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 the ineligibility begins, shall be eligible for Medicaid for an additional four (4) months beginning with the month in which the ineligibility begins. The eligibility of the individuals covered under this paragraph shall be determined by the division.

(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.

(23) Children certified by the Mississippi Department of Human Services for whom the state and county departments of human services have 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) The division shall apply to the Centers for Medicare and Medicaid Services (CMS) for any necessary waivers to provide services to 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 level 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, and who are not otherwise covered by Medicare. Nothing contained in this paragraph (25) shall entitle an individual to benefits. The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid.

(26) The division shall apply to the Centers for Medicare and Medicaid Services (CMS) for any necessary waivers to provide services to 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, who are end stage renal disease patients on dialysis, cancer patients on chemotherapy or organ transplant recipients on antirejection drugs, whose income does not exceed one hundred thirty-five percent (135%) of the nonfarm official poverty level as defined by the Office of Management and Budget and revised annually, and whose resources do not exceed those established by the division. Nothing contained in this paragraph (26) shall entitle an individual to benefits. The eligibility of individuals covered under this paragraph shall be determined by the Division of Medicaid.

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

(28) The division is authorized and directed to provide up to twelve (12) months of continuous coverage postpartum for any individual who qualifies for Medicaid coverage under this section as a pregnant woman, to the extent allowable under federal law and as determined by the division.

(29) Individuals who are eligible under any waivers applied for under Sections 1 through 8 of this act that are approved by the Centers for Medicare and Medicaid Services.

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

**SECTION 11.** This act shall take effect and be in force from and after July 1, 2024.