

By: Representatives White, McGee, Scott, McCray, Karriem, McLean, Summers, Denton

To: Medicaid

HOUSE BILL NO. 1725

1 AN ACT TO DIRECT THE DIVISION OF MEDICAID TO ENTER INTO  
2 NEGOTIATIONS WITH THE FEDERAL GOVERNMENT TO OBTAIN A WAIVER OF  
3 APPLICABLE PROVISIONS OF THE MEDICAID LAWS AND REGULATIONS TO  
4 CREATE A PLAN TO ALLOW MEDICAID COVERAGE IN MISSISSIPPI FOR  
5 INDIVIDUALS DESCRIBED IN THE FEDERAL AFFORDABLE CARE ACT, TO BE  
6 KNOWN AS HEALTHY MISSISSIPPI WORKS (HMW); TO SPECIFY THE  
7 PROVISIONS THAT THE DIVISION SHALL SEEK TO HAVE INCLUDED IN THE  
8 WAIVER PLAN, WHICH INCLUDE THE COVERAGE GROUP, COPAYMENTS FOR  
9 NONEMERGENCY USE OF THE EMERGENCY ROOM, BENEFIT PACKAGES, FUNDING  
10 OF THE PLAN, AND THE TIMING FOR APPROVAL OF THE WAIVER; TO PROVIDE  
11 THAT THE COVERAGE GROUP FOR ELIGIBILITY UNDER HMW SHALL BE  
12 INDIVIDUALS WHO ARE 19 THROUGH 64 YEARS OF AGE WHOSE INCOME IS NOT  
13 MORE THAN 138% OF THE FEDERAL POVERTY LEVEL, AND TO THE EXTENT  
14 APPROVED IN THE WAIVER, WHO ARE EMPLOYED FOR AT LEAST TWENTY HOURS  
15 PER WEEK IN A POSITION FOR WHICH HEALTH INSURANCE IS NOT PROVIDED  
16 BY THE EMPLOYER OR ENROLLED AS A FULL TIME STUDENT IN SECONDARY OR  
17 POST-SECONDARY EDUCATION OR ENROLLED FULL TIME IN A WORKFORCE  
18 TRAINING PROGRAM; TO PROVIDE THAT THE COVERAGE GROUP SHALL NOT  
19 INCLUDE INDIVIDUALS WHO HAVE HEALTH INSURANCE COVERAGE THROUGH  
20 THEIR EMPLOYER OR PRIVATE HEALTH INSURANCE AND WHO VOLUNTARILY  
21 DISENROLL FROM THAT HEALTH INSURANCE COVERAGE UNTIL TWELVE MONTHS  
22 AFTER THE ENDING DATE OF THAT COVERAGE; TO PROVIDE THAT THE  
23 COVERAGE GROUP SHALL NOT INCLUDE NON-UNITED STATES CITIZENS WHO  
24 ARE INELIGIBLE FOR MEDICAID BENEFITS; TO PROVIDE THAT ALL  
25 INDIVIDUALS IN THE COVERAGE GROUP SHALL BE ENROLLED IN AND THEIR  
26 SERVICES SHALL BE PROVIDED BY THE MANAGED CARE ORGANIZATIONS  
27 (MCOS), COORDINATED CARE ORGANIZATIONS (CCOS) PROVIDER-SPONSORED  
28 HEALTH PLANS (PSHPS) AND OTHER SUCH ORGANIZATIONS PAID FOR  
29 SERVICES TO THE MEDICAID POPULATION ON A CAPITATED BASIS BY THE  
30 DIVISION; TO PROVIDE THAT ALL INDIVIDUALS IN THE COVERAGE GROUP  
31 ENROLLED UNDER HMW MUST PAY A COPAYMENT OF TEN DOLLARS FOR  
32 NONEMERGENCY USE OF THE EMERGENCY ROOM, WHICH COPAYMENT WILL BE  
33 WAIVED UNDER CERTAIN CIRCUMSTANCES; TO PROVIDE THAT INDIVIDUALS IN  
34 THE COVERAGE GROUP ENROLLED UNDER HMW WHO ARE 19 OR 20 YEARS OF



35 AGE WILL RECEIVE ALL EPSDT BENEFITS TO WHICH THEY MAY BE ENTITLED  
36 UNDER FEDERAL LAW AND REGULATION; TO PROVIDE THAT INDIVIDUALS  
37 ENROLLED UNDER HMW WHO ARE 21 THROUGH 64 YEARS OF AGE WILL HAVE  
38 ACCESS TO THE STATE PLAN BENEFIT PACKAGE FOR ADULTS ELIGIBLE UNDER  
39 THE FEDERAL AFFORDABLE CARE ACT; TO PROVIDE THAT THE MCOS, CCOS,  
40 PSHPS AND OTHER SUCH ORGANIZATIONS SHALL PROVIDE THE FOLLOWING  
41 SERVICES TO ASSIST INDIVIDUALS ENROLLED UNDER HMW WITH RESOURCES  
42 TO ENHANCE THEIR WORKFORCE OPPORTUNITIES: WORKFORCE TRAINING AND  
43 SKILLS-BUILDING TO ASSIST THE INDIVIDUAL WITH FINDING A JOB OR  
44 ADVANCING THEIR CAREER, AND FINANCIAL LITERACY MATERIALS TO  
45 PROMOTE WISE FINANCIAL DECISION-MAKING; TO PROVIDE THAT IF THE  
46 FEDERAL MATCHING FUND PROPORTION FOR MEDICAL SERVICES PROVIDED TO  
47 THE HMW POPULATION EVER FALLS BELOW 90%, THE WAIVER FOR HMW SHALL  
48 BE DISCONTINUED TO COINCIDE WITH THE EFFECTIVE DATE OF SUCH A  
49 DECREASE IN THE FEDERAL MATCHING FUND PROPORTION; TO PROVIDE THAT  
50 THE STATE MATCHING FUNDS FOR HMW SHALL INCLUDE CONTRIBUTIONS FROM  
51 HOSPITALS THAT ARE GENERATED THROUGH AN ASSESSMENT ON HOSPITALS  
52 AND CONTRIBUTIONS FROM MCOS, CCOS, PSHPS AND OTHER SUCH  
53 ORGANIZATIONS IN THE FORM OF AN ASSESSMENT AS PROVIDED IN THIS  
54 ACT; TO PROVIDE IF THE WAIVER AS DESCRIBED IN THIS ACT IS NOT  
55 SUBSTANTIALLY APPROVED BEFORE SEPTEMBER 30, 2024, OR IF THE WAIVER  
56 IS APPROVED BUT IS SUBSEQUENTLY TERMINATED, THEN THE DIVISION  
57 SHALL ALLOW FOR MEDICAID COVERAGE IN MISSISSIPPI FOR INDIVIDUALS  
58 DESCRIBED IN THE FEDERAL AFFORDABLE CARE ACT, TO BE KNOWN AS THE  
59 HEALTHY MISSISSIPPI WORKS (HMW) CATEGORY OF ELIGIBILITY, AND SHALL  
60 MOVE WITH ALL DELIBERATE SPEED TO SUBMIT THE REQUIRED STATE PLAN  
61 AMENDMENTS TO EFFECTUATE MEDICAID COVERAGE FOR THOSE INDIVIDUALS;  
62 TO PROVIDE THAT THE COVERAGE GROUP, DELIVERY SYSTEMS, BENEFIT  
63 PACKAGES AND FUNDING OF THE HMW CATEGORY OF ELIGIBILITY WILL BE  
64 SUBSTANTIALLY THE SAME AS THOSE IN THE WAIVER PLAN; TO PROVIDE FOR  
65 THE LEVY OF AN ASSESSMENT UPON EACH MANAGED CARE ORGANIZATION,  
66 COORDINATED CARE ORGANIZATION, PROVIDER SPONSORED HEALTH PLAN OR  
67 OTHER ORGANIZATION PAID FOR SERVICES ON A CAPITATED BASIS BY THE  
68 DIVISION, IN THE AMOUNT OF FOUR PERCENT ON THE TOTAL PAID  
69 CAPITATION, EXCLUDING ANY SUCH PAID AMOUNT THAT IS ATTRIBUTABLE TO  
70 SUPPLEMENTAL PAYMENTS; TO AMEND SECTION 43-13-115, MISSISSIPPI  
71 CODE OF 1972, TO CONFORM TO THE PRECEDING PROVISIONS; TO PROVIDE  
72 THAT ALL OF THE PROVISIONS OF THIS ACT SHALL STAND REPEALED ON  
73 JANUARY 31, 2029; AND FOR RELATED PURPOSES.

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

75 **SECTION 1.** (1) The Office of the Governor, Division of  
76 Medicaid shall enter into negotiations with the Centers for  
77 Medicare and Medicaid Services (CMS) to obtain a waiver of  
78 applicable provisions of the Medicaid laws and regulations under  
79 Section 1115 of the Social Security Act to create a plan to allow



80 Medicaid coverage in Mississippi for individuals described in  
81 Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act as  
82 described in the federal Affordable Care Act and as eligible under  
83 this act, to be known as Healthy Mississippi Works (HMW), which  
84 contains the following provisions:

85           (a) **Coverage group.** Individuals eligible for coverage  
86 under HMW shall be persons who are not less than nineteen (19)  
87 years of age but less than sixty-five (65) years of age, who  
88 currently reside in households that have an income of not more  
89 than one hundred thirty-eight percent (138%) of federal poverty  
90 level or as otherwise described in Section 1902(a)(10)(A)(i)(VIII)  
91 of the Social Security Act and, to the extent approved by CMS in  
92 the Section 1115 waiver, who are employed for at least twenty (20)  
93 hours per week in a position for which health insurance is not  
94 provided by the employer or enrolled as a full-time student in  
95 secondary or post-secondary education or enrolled full-time in a  
96 workforce training program. Any individual otherwise eligible for  
97 coverage under HMW who has health insurance coverage through his  
98 or her employer or through private health insurance and who  
99 voluntarily disenrolls from that health insurance coverage shall  
100 not be in the coverage group until twelve (12) months after the  
101 ending date of that coverage. The coverage group shall not  
102 include non-United States citizens who are ineligible for Medicaid  
103 benefits.



104           (b) **Delivery systems.** All individuals in the coverage  
105 group shall be enrolled in and their services shall be provided by  
106 the managed care organizations (MCOs), coordinated care  
107 organizations (CCOs), provider-sponsored health plans (PSHPs) and  
108 other such organizations paid for services to the Medicaid  
109 population on a capitated basis by the division as described in  
110 Section 43-13-117(H).

111           (c) **Copayments for nonemergency use.** All individuals  
112 in the coverage group enrolled under HMW must pay a copayment of  
113 Ten Dollars (\$10.00) for nonemergency use of the emergency room  
114 (ER), which will be waived if the individual calls the  
115 twenty-four-hour nurse hotline of the MCO, CCO, PSHP or other such  
116 organization before using the ER. These copayments will be  
117 refunded if the individual has an emergency condition or is  
118 admitted to the hospital on the same day.

119           (d) **Benefit packages.** (i) Individuals in the coverage  
120 group enrolled under HMW who are not less than nineteen (19) years  
121 of age but less than twenty-one (21) years of age will receive all  
122 Early and Periodic, Screening, Diagnosis and Treatment program  
123 (EPSDT) benefits to which they may be entitled under federal law  
124 and regulation. Individuals enrolled under HMW who are not less  
125 than twenty-one (21) years of age but less than sixty-five (65)  
126 years of age will have access to the state plan benefit package  
127 for adults eligible under Section 1902(a)(10)(A)(i)(VIII) of the



128 Social Security Act and as described by the Division of Medicaid  
129 and approved by CMS.

130 (ii) In addition, MCOs, CCOs, PSHPs and other such  
131 organizations paid for services to the Medicaid population on a  
132 capitated basis by the division as described in Section  
133 43-13-117(H) shall provide the following services to assist  
134 individuals enrolled under HMW with resources to enhance their  
135 workforce opportunities: (i) workforce training and  
136 skills-building to assist the individual with finding a job or  
137 advancing their career; additionally, individuals enrolled under  
138 HMW who have been incarcerated within the last three (3) years  
139 shall be provided a special case liaison to assist with finding or  
140 maintaining housing, food, health care and workforce training; and  
141 (ii) financial literacy materials to promote wise financial  
142 decision-making. The MCOs, CCOs, PSHPs and other such  
143 organizations described in this paragraph (d) shall report the  
144 services provided to individuals enrolled under HMW on an annual  
145 basis to the division.

146 (e) **Funding of the plan.** (i) The Section 1115 waiver  
147 described in this section shall describe the funding for HMW,  
148 which shall be a combination of state matching funds and federal  
149 matching funds in the proportions specified under the federal  
150 Affordable Care Act at the time of the effective date of this act.

151 (ii) If the federal matching fund proportion for  
152 medical services provided to the HMW population ever falls below



153 ninety percent (90%), the waiver for HMW shall be discontinued to  
154 coincide with the effective date of such a decrease in the federal  
155 matching fund proportion or as close to that date as required in  
156 order for the division to comply with any federal notice and due  
157 process requirements.

158 (iii) The state matching funds shall include  
159 contributions from hospitals that are generated through an  
160 assessment on hospitals as described in Section 43-13-145 and  
161 deposited into the Medical Care Fund created in Section 43-13-143.  
162 The state matching funds shall also include contributions from  
163 MCOs, CCOs, PSHPs and other such organizations paid for services  
164 to the Medicaid population on a capitated basis by the division as  
165 described in Section 43-13-117(H) in the form of an assessment as  
166 provided in Section 3 of this act.

167 (iv) The division is also authorized to accept any  
168 voluntary contributions donated to the division to be used as  
169 state matching funds for HMW, including, but not limited to,  
170 contributions from businesses and other entities. Notwithstanding  
171 any provision of this paragraph (e), state matching funds for HMW  
172 may be appropriated by the Legislature from any other sources.

173 (f) **Timing.** If the waiver as described in this section  
174 is not substantially approved by CMS before September 30, 2024,  
175 for an effective date of enrollment and coverage from January 1,  
176 2025, through January 31, 2029, then the provisions of Section 2  
177 of this act shall become effective.



178 (2) This section shall stand repealed on January 31, 2029.

179 **SECTION 2.** (1) The provisions of this section shall become  
180 effective if the Section 1115 waiver described in Section 1 of  
181 this act is not substantially approved by the Centers for Medicare  
182 and Medicaid Services (CMS) before September 30, 2024, or if the  
183 waiver is approved but is subsequently terminated.

184 (2) The Office of the Governor, Division of Medicaid shall  
185 allow for Medicaid coverage in Mississippi for individuals  
186 described in Section 1902(a)(10)(A)(i)(VIII) of the Social  
187 Security Act as described in the federal Affordable Care Act and  
188 as eligible under this act, to be known as the Healthy Mississippi  
189 Works (HMW) category of eligibility, and shall move with all  
190 deliberate speed to submit to CMS the required State Plan  
191 Amendments and any other items required under federal or state law  
192 to effectuate Medicaid coverage beginning on January 1, 2025, for  
193 those individuals as described in this section.

194 (a) **Coverage group.** Individuals eligible for coverage  
195 under the HMW category of eligibility shall be persons who are not  
196 less than nineteen (19) years of age but less than sixty-five (65)  
197 years of age, who currently reside in households that have an  
198 income of not more than one hundred thirty-eight percent (138%) of  
199 federal poverty level or as otherwise described in Section  
200 1902(a)(10)(A)(i)(VIII) of the Social Security Act. Any  
201 individual otherwise eligible for coverage under HMW who has  
202 health insurance coverage through his or her employer or through



203 private health insurance and who voluntarily disenrolls from that  
204 health insurance coverage shall not be in the coverage group until  
205 twelve (12) months after the ending date of that coverage. The  
206 coverage group shall not include non-United States citizens who  
207 are ineligible for Medicaid benefits.

208 (b) **Delivery systems.** All individuals in the coverage  
209 group shall be enrolled in and their services shall be provided by  
210 the managed care organizations (MCOs), coordinated care  
211 organizations (CCOs), provider-sponsored health plans (PSHPs) and  
212 other such organizations paid for services to the Medicaid  
213 population on a capitated basis by the division as described in  
214 Section 43-13-117(H).

215 (c) **Copayments for nonemergency use.** To the extent  
216 allowable under federal law, all individuals in the coverage group  
217 must pay a copayment of Ten Dollars (\$10.00) for nonemergency use  
218 of the emergency room (ER), which will be waived if the individual  
219 calls the twenty-four-hour nurse hotline of the MCO, CCO, PSHP or  
220 other such organization before using the ER. These copayments  
221 will be refunded if the individual has an emergency condition or  
222 is admitted to the hospital on the same day.

223 (d) **Benefit packages.** (i) Individuals in the coverage  
224 group who are not less than nineteen (19) years of age but less  
225 than twenty-one (21) years of age will receive all Early and  
226 Periodic, Screening, Diagnosis and Treatment program (EPSDT)  
227 benefits to which they may be entitled under federal law and





228 regulation. Individuals in the coverage group who are not less  
229 than twenty-one (21) years of age but less than sixty-five (65)  
230 years of age will have access to the state plan benefit package  
231 for adults eligible under Section 1902(a)(10)(A)(i)(VIII) of the  
232 Social Security Act and as described by the Division of Medicaid  
233 and approved by CMS.

234 (ii) In addition, MCOs, CCOs, PSHPs and other such  
235 organizations paid for services to the Medicaid population on a  
236 capitated basis by the division as described in Section  
237 43-13-117(H) shall provide the following services to assist  
238 individuals in the coverage group with resources to enhance their  
239 workforce opportunities: (i) workforce training and  
240 skills-building to assist the individual with finding a job or  
241 advancing their career; additionally, individuals enrolled under  
242 HMW who have been incarcerated within the last three (3) years  
243 shall be provided a special case liaison to assist with finding or  
244 maintaining housing, food, health care and workforce training; and  
245 (ii) financial literacy materials to promote wise financial  
246 decision-making. The MCOs, CCOs, PSHPs and other such  
247 organizations described in this paragraph (d) shall report the  
248 services provided to individuals in the coverage group on an  
249 annual basis to the division.

250 (e) **Funding of the plan.** (i) Funding for the HMW  
251 category of eligibility shall be a combination of state matching  
252 funds and federal matching funds in the proportions specified



253 under the federal Affordable Care Act at the time of the effective  
254 date of this act.

255 (ii) If the federal matching fund proportion for  
256 medical services provided to the HMW population ever falls below  
257 ninety percent (90%), the HMW category of eligibility shall be  
258 discontinued to coincide with the effective date of such a  
259 decrease in the federal matching fund proportion or as close to  
260 that date as required in order for the division to comply with any  
261 federal notice and due process requirements.

262 (iii) The state matching funds shall include  
263 contributions from hospitals that are generated through an  
264 assessment on hospitals as described in Section 43-13-145 and  
265 deposited into the Medical Care Fund created in Section 43-13-143.  
266 The state matching funds shall also include contributions from  
267 MCOs, CCOs, PSHPs and other such organizations paid for services  
268 to the Medicaid population on a capitated basis by the division as  
269 described in Section 43-13-117(H) in the form of an assessment as  
270 described in Section 3 of this act.

271 (iv) The division is also authorized to accept any  
272 voluntary contributions donated to the division to be used as  
273 state matching funds for the HMW category of eligibility,  
274 including, but not limited to, contributions from businesses and  
275 other entities. Notwithstanding any provision of this paragraph  
276 (e), state matching funds for the HMW category of eligibility may  
277 be appropriated by the Legislature from any other sources.



278 (3) This section shall stand repealed on January 31, 2029.

279 **SECTION 3.** (1) Notwithstanding any other provision of law,  
280 upon each managed care organization, coordinated care  
281 organization, provider sponsored health plan or other organization  
282 paid for services to the Medicaid population on a capitated basis  
283 by the Division of Medicaid as described in Section 43-13-117(H),  
284 there is levied an assessment of four percent (4%) on the total  
285 paid capitation, excluding any such paid amount that is  
286 attributable to supplemental payments. All assessments under this  
287 section shall be assessed and collected by the division on the  
288 15th of each month and shall be deposited into the Medical Care  
289 Fund created by Section 43-13-143. This section shall be  
290 effective in the first month that a capitated payment is provided  
291 to a managed care organization, coordinated care organization,  
292 provider sponsored health plan or other organization paid for  
293 services to the Medicaid population on a capitated basis by the  
294 division as described in Section 43-13-117(H) for coverage of  
295 individuals eligible under Section 1902(a)(10)(A)(i)(VIII) of the  
296 Social Security Act.

297 (2) This section shall stand repealed on January 31, 2029.

298 **SECTION 4.** Section 43-13-115, Mississippi Code of 1972, is  
299 amended as follows:

300 43-13-115. Recipients of Medicaid shall be the following  
301 persons only:



302 (1) Those who are qualified for public assistance grants  
303 under provisions of Title IV-A and E of the federal Social  
304 Security Act, as amended, including those statutorily deemed to be  
305 IV-A and low income families and children under Section 1931 of  
306 the federal Social Security Act. For the purposes of this  
307 paragraph (1) and paragraphs (8), (17) and (18) of this section,  
308 any reference to Title IV-A or to Part A of Title IV of the  
309 federal Social Security Act, as amended, or the state plan under  
310 Title IV-A or Part A of Title IV, shall be considered as a  
311 reference to Title IV-A of the federal Social Security Act, as  
312 amended, and the state plan under Title IV-A, including the income  
313 and resource standards and methodologies under Title IV-A and the  
314 state plan, as they existed on July 16, 1996. The Department of  
315 Human Services shall determine Medicaid eligibility for children  
316 receiving public assistance grants under Title IV-E. The division  
317 shall determine eligibility for low income families under Section  
318 1931 of the federal Social Security Act and shall redetermine  
319 eligibility for those continuing under Title IV-A grants.

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



326 (3) Qualified pregnant women who would be eligible for  
327 Medicaid as a low income family member under Section 1931 of the  
328 federal Social Security Act if her child were born. The  
329 eligibility of the individuals covered under this paragraph shall  
330 be determined by the division.

331 (4) [Deleted]

332 (5) A child born on or after October 1, 1984, to a woman  
333 eligible for and receiving Medicaid under the state plan on the  
334 date of the child's birth shall be deemed to have applied for  
335 Medicaid and to have been found eligible for Medicaid under the  
336 plan on the date of that birth, and will remain eligible for  
337 Medicaid for a period of one (1) year so long as the child is a  
338 member of the woman's household and the woman remains eligible for  
339 Medicaid or would be eligible for Medicaid if pregnant. The  
340 eligibility of individuals covered in this paragraph shall be  
341 determined by the Division of Medicaid.

342 (6) Children certified by the State Department of Human  
343 Services to the Division of Medicaid of whom the state and county  
344 departments of human services have custody and financial  
345 responsibility, and children who are in adoptions subsidized in  
346 full or part by the Department of Human Services, including  
347 special needs children in non-Title IV-E adoption assistance, who  
348 are approvable under Title XIX of the Medicaid program. The  
349 eligibility of the children covered under this paragraph shall be  
350 determined by the State Department of Human Services.



351 (7) Persons certified by the Division of Medicaid who are  
352 patients in a medical facility (nursing home, hospital,  
353 tuberculosis sanatorium or institution for treatment of mental  
354 diseases), and who, except for the fact that they are patients in  
355 that medical facility, would qualify for grants under Title IV,  
356 Supplementary Security Income (SSI) benefits under Title XVI or  
357 state supplements, and those aged, blind and disabled persons who  
358 would not be eligible for Supplemental Security Income (SSI)  
359 benefits under Title XVI or state supplements if they were not  
360 institutionalized in a medical facility but whose income is below  
361 the maximum standard set by the Division of Medicaid, which  
362 standard shall not exceed that prescribed by federal regulation.

363 (8) Children under eighteen (18) years of age and pregnant  
364 women (including those in intact families) who meet the financial  
365 standards of the state plan approved under Title IV-A of the  
366 federal Social Security Act, as amended. The eligibility of  
367 children covered under this paragraph shall be determined by the  
368 Division of Medicaid.

369 (9) Individuals who are:

370 (a) Children born after September 30, 1983, who have  
371 not attained the age of nineteen (19), with family income that  
372 does not exceed one hundred percent (100%) of the nonfarm official  
373 poverty level;

374 (b) Pregnant women, infants and children who have not  
375 attained the age of six (6), with family income that does not



376 exceed one hundred thirty-three percent (133%) of the federal  
377 poverty level; and

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

381 The eligibility of individuals covered in (a), (b) and (c) of  
382 this paragraph shall be determined by the division.

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

392 (11) Until the end of the day on December 31, 2005,  
393 individuals who are sixty-five (65) years of age or older or are  
394 disabled as determined under Section 1614(a)(3) of the federal  
395 Social Security Act, as amended, and whose income does not exceed  
396 one hundred thirty-five percent (135%) of the nonfarm official  
397 poverty level as defined by the Office of Management and Budget  
398 and revised annually, and whose resources do not exceed those  
399 established by the Division of Medicaid. The eligibility of  
400 individuals covered under this paragraph shall be determined by



401 the Division of Medicaid. After December 31, 2005, only those  
402 individuals covered under the 1115(c) Healthier Mississippi waiver  
403 will be covered under this category.

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

414 (12) Individuals who are qualified Medicare beneficiaries  
415 (QMB) entitled to Part A Medicare as defined under Section 301,  
416 Public Law 100-360, known as the Medicare Catastrophic Coverage  
417 Act of 1988, and whose income does not exceed one hundred percent  
418 (100%) of the nonfarm official poverty level as defined by the  
419 Office of Management and Budget and revised annually.

420 The eligibility of individuals covered under this paragraph  
421 shall be determined by the Division of Medicaid, and those  
422 individuals determined eligible shall receive Medicare  
423 cost-sharing expenses only as more fully defined by the Medicare  
424 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of  
425 1997.





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

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

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

444           (14) [Deleted]

445           (15) Disabled workers who are eligible to enroll in Part A  
446 Medicare as required by Public Law 101-239, known as the Omnibus  
447 Budget Reconciliation Act of 1989, and whose income does not  
448 exceed two hundred percent (200%) of the federal poverty level as  
449 determined in accordance with the Supplemental Security Income  
450 (SSI) program. The eligibility of individuals covered under this



451 paragraph shall be determined by the Division of Medicaid and  
452 those individuals shall be entitled to buy-in coverage of Medicare  
453 Part A premiums only under the provisions of this paragraph (15).

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

460 (17) In accordance with the terms of the federal Personal  
461 Responsibility and Work Opportunity Reconciliation Act of 1996  
462 (Public Law 104-193), persons who become ineligible for assistance  
463 under Title IV-A of the federal Social Security Act, as amended,  
464 because of increased income from or hours of employment of the  
465 caretaker relative or because of the expiration of the applicable  
466 earned income disregards, who were eligible for Medicaid for at  
467 least three (3) of the six (6) months preceding the month in which  
468 the ineligibility begins, shall be eligible for Medicaid for up to  
469 twelve (12) months. The eligibility of the individuals covered  
470 under this paragraph shall be determined by the division.

471 (18) Persons who become ineligible for assistance under  
472 Title IV-A of the federal Social Security Act, as amended, as a  
473 result, in whole or in part, of the collection or increased  
474 collection of child or spousal support under Title IV-D of the  
475 federal Social Security Act, as amended, who were eligible for



476 Medicaid for at least three (3) of the six (6) months immediately  
477 preceding the month in which the ineligibility begins, shall be  
478 eligible for Medicaid for an additional four (4) months beginning  
479 with the month in which the ineligibility begins. The eligibility  
480 of the individuals covered under this paragraph shall be  
481 determined by the division.

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

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

492 (21) Women of childbearing age whose family income does not  
493 exceed one hundred eighty-five percent (185%) of the federal  
494 poverty level. The eligibility of individuals covered under this  
495 paragraph (21) shall be determined by the Division of Medicaid,  
496 and those individuals determined eligible shall only receive  
497 family planning services covered under Section 43-13-117(13) and  
498 not any other services covered under Medicaid. However, any  
499 individual eligible under this paragraph (21) who is also eligible  
500 under any other provision of this section shall receive the



501 benefits to which he or she is entitled under that other  
502 provision, in addition to family planning services covered under  
503 Section 43-13-117(13).

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

512 (22) Persons who are workers with a potentially severe  
513 disability, as determined by the division, shall be allowed to  
514 purchase Medicaid coverage. The term "worker with a potentially  
515 severe disability" means a person who is at least sixteen (16)  
516 years of age but under sixty-five (65) years of age, who has a  
517 physical or mental impairment that is reasonably expected to cause  
518 the person to become blind or disabled as defined under Section  
519 1614(a) of the federal Social Security Act, as amended, if the  
520 person does not receive items and services provided under  
521 Medicaid.

522 The eligibility of persons under this paragraph (22) shall be  
523 conducted as a demonstration project that is consistent with  
524 Section 204 of the Ticket to Work and Work Incentives Improvement  
525 Act of 1999, Public Law 106-170, for a certain number of persons



526 as specified by the division. The eligibility of individuals  
527 covered under this paragraph (22) shall be determined by the  
528 Division of Medicaid.

529 (23) Children certified by the Mississippi Department of  
530 Human Services for whom the state and county departments of human  
531 services have custody and financial responsibility who are in  
532 foster care on their eighteenth birthday as reported by the  
533 Mississippi Department of Human Services shall be certified  
534 Medicaid eligible by the Division of Medicaid until their  
535 twenty-first birthday.

536 (24) Individuals who have not attained age sixty-five (65),  
537 are not otherwise covered by creditable coverage as defined in the  
538 Public Health Services Act, and have been screened for breast and  
539 cervical cancer under the Centers for Disease Control and  
540 Prevention Breast and Cervical Cancer Early Detection Program  
541 established under Title XV of the Public Health Service Act in  
542 accordance with the requirements of that act and who need  
543 treatment for breast or cervical cancer. Eligibility of  
544 individuals under this paragraph (24) shall be determined by the  
545 Division of Medicaid.

546 (25) The division shall apply to the Centers for Medicare  
547 and Medicaid Services (CMS) for any necessary waivers to provide  
548 services to individuals who are sixty-five (65) years of age or  
549 older or are disabled as determined under Section 1614(a)(3) of  
550 the federal Social Security Act, as amended, and whose income does



551 not exceed one hundred thirty-five percent (135%) of the nonfarm  
552 official poverty level as defined by the Office of Management and  
553 Budget and revised annually, and whose resources do not exceed  
554 those established by the Division of Medicaid, and who are not  
555 otherwise covered by Medicare. Nothing contained in this  
556 paragraph (25) shall entitle an individual to benefits. The  
557 eligibility of individuals covered under this paragraph shall be  
558 determined by the Division of Medicaid.

559 (26) The division shall apply to the Centers for Medicare  
560 and Medicaid Services (CMS) for any necessary waivers to provide  
561 services to individuals who are sixty-five (65) years of age or  
562 older or are disabled as determined under Section 1614(a)(3) of  
563 the federal Social Security Act, as amended, who are end stage  
564 renal disease patients on dialysis, cancer patients on  
565 chemotherapy or organ transplant recipients on antirejection  
566 drugs, whose income does not exceed one hundred thirty-five  
567 percent (135%) of the nonfarm official poverty level as defined by  
568 the Office of Management and Budget and revised annually, and  
569 whose resources do not exceed those established by the division.  
570 Nothing contained in this paragraph (26) shall entitle an  
571 individual to benefits. The eligibility of individuals covered  
572 under this paragraph shall be determined by the Division of  
573 Medicaid.

574 (27) Individuals who are entitled to Medicare Part D and  
575 whose income does not exceed one hundred fifty percent (150%) of



576 the nonfarm official poverty level as defined by the Office of  
577 Management and Budget and revised annually. Eligibility for  
578 payment of the Medicare Part D subsidy under this paragraph shall  
579 be determined by the division.

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

585 (29) Individuals described in Section  
586 1902(a)(10)(A)(i)(VIII) of the Social Security Act who are  
587 eligible under either Section 1 or Section 2 of this act, provided  
588 that the federal matching funds percentage for medical services  
589 provided for this category of individuals does not fall below  
590 ninety percent (90%). If the federal matching funds percentage  
591 for medical services falls below ninety percent (90%), then the  
592 division's coverage of these individuals shall be discontinued as  
593 expeditiously as possible pursuant to federal law. This paragraph  
594 (29) shall stand repealed on January 31, 2029.

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

598 **SECTION 5.** If any section, paragraph, sentence, clause,  
599 phrase or any part of this act is declared to be unconstitutional  
600 or void, or if for any reason is declared to be invalid or of no



601 effect, the remaining sections, paragraphs, sentences, clauses,  
602 phrases or parts of this act shall be in no manner affected  
603 thereby but shall remain in full force and effect.

604           **SECTION 6.** This act shall take effect and be in force from  
605 and after its passage.

