MISSISSIPPI LEGISLATURE REGULAR SESSION 2024

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.

ST: Medicaid; seek federal waiver for plan to allow Medicaid coverage for persons described in the federal Affordable Care Act.