HOUSE BILL NO. 1725

AN ACT TO DIRECT THE DIVISION OF MEDICAID TO ENTER INTO NEGOTIATIONS WITH THE FEDERAL GOVERNMENT TO OBTAIN A WAIVER OF APPLICABLE PROVISIONS OF THE MEDICAID LAWS AND REGULATIONS TO CREATE A PLAN TO ALLOW MEDICAID COVERAGE IN MISSISSIPPI FOR INDIVIDUALS DESCRIBED IN THE FEDERAL AFFORDABLE CARE ACT, TO BE KNOWN AS HEALTHY MISSISSIPPI WORKS (HMW); TO SPECIFY THE PROVISIONS THAT THE DIVISION SHALL SEEK TO HAVE INCLUDED IN THE WAIVER PLAN, WHICH INCLUDE THE COVERAGE GROUP, COPAYMENTS FOR NONEMERGENCY USE OF THE EMERGENCY ROOM, BENEFIT PACKAGES, FUNDING OF THE PLAN, AND THE TIMING FOR APPROVAL OF THE WAIVER; TO PROVIDE THAT THE COVERAGE GROUP FOR ELIGIBILITY UNDER HMW SHALL BE INDIVIDUALS WHO ARE 19 THROUGH 64 YEARS OF AGE WHOSE INCOME IS NOT MORE THAN 138% OF THE FEDERAL POVERTY LEVEL, AND TO THE EXTENT APPROVED IN THE WAIVER, WHO ARE EMPLOYED FOR AT LEAST TWENTY HOURS PER WEEK IN A POSITION FOR WHICH HEALTH INSURANCE IS NOT PROVIDED BY THE EMPLOYER OR ENROLLED AS A FULL TIME STUDENT IN SECONDARY OR POST-SECONDARY EDUCATION OR ENROLLED FULL TIME IN A WORKFORCE TRAINING PROGRAM; TO PROVIDE THAT THE COVERAGE GROUP SHALL NOT INCLUDE INDIVIDUALS WHO HAVE HEALTH INSURANCE COVERAGE THROUGH THEIR EMPLOYER OR PRIVATE HEALTH INSURANCE AND WHO VOLUNTARILY DISENROLL FROM THAT HEALTH INSURANCE COVERAGE UNTIL TWELVE MONTHS AFTER THE ENDING DATE OF THAT COVERAGE; TO PROVIDE THAT THE COVERAGE GROUP SHALL NOT INCLUDE NON-UNITED STATES CITIZENS WHO ARE INELIGIBLE FOR MEDICAID BENEFITS; TO PROVIDE THAT ALL INDIVIDUALS IN THE COVERAGE GROUP SHALL BE ENROLLED IN AND THEIR SERVICES SHALL BE PROVIDED BY THE MANAGED CARE ORGANIZATIONS (MCOS), COORDINATED CARE ORGANIZATIONS (CCOS) PROVIDER-SPONSORED HEALTH PLANS (PSHPs) AND OTHER SUCH ORGANIZATIONS PAID FOR SERVICES TO THE MEDICAID POPULATION ON A CAPITATED BASIS BY THE DIVISION; TO PROVIDE THAT ALL INDIVIDUALS IN THE COVERAGE GROUP ENROLLED UNDER HMW MUST PAY A COPAYMENT OF TEN DOLLARS FOR NONEMERGENCY USE OF THE EMERGENCY ROOM, WHICH COPAYMENT WILL BE WAIVED UNDER CERTAIN CIRCUMSTANCES; TO PROVIDE THAT INDIVIDUALS IN THE COVERAGE GROUP ENROLLED UNDER HMW WHO ARE 19 OR 20 YEARS OF AGE.
AGE WILL RECEIVE ALL EPSDT BENEFITS TO WHICH THEY MAY BE ENTITLED UNDER FEDERAL LAW AND REGULATION; TO PROVIDE THAT INDIVIDUALS ENROLLED UNDER HMW WHO ARE 21 THROUGH 64 YEARS OF AGE WILL HAVE ACCESS TO THE STATE PLAN BENEFIT PACKAGE FOR ADULTS ELIGIBLE UNDER THE FEDERAL AFFORDABLE CARE ACT; TO PROVIDE THAT THE MCOS, CCOS, PSHPs AND OTHER SUCH ORGANIZATIONS SHALL PROVIDE THE FOLLOWING SERVICES TO ASSIST INDIVIDUALS ENROLLED UNDER HMW WITH RESOURCES TO ENHANCE THEIR WORKFORCE OPPORTUNITIES: WORKFORCE TRAINING AND SKILLS-BUILDING TO ASSIST THE INDIVIDUAL WITH FINDING A JOB OR ADVANCING THEIR CAREER, AND FINANCIAL LITERACY MATERIALS TO PROMOTE WISE FINANCIAL DECISION-MAKING; TO PROVIDE THAT IF THE FEDERAL MATCHING FUND PROPORTION FOR MEDICAL SERVICES PROVIDED TO THE HMW POPULATION EVER FALLS BELOW 90%, THE WAIVER FOR HMW SHALL BE DISCONTINUED TO COINCIDE WITH THE EFFECTIVE DATE OF SUCH A DECREASE IN THE FEDERAL MATCHING FUND PROPORTION; TO PROVIDE THAT THE STATE MATCHING FUNDS FOR HMW SHALL INCLUDE CONTRIBUTIONS FROM HOSPITALS THAT ARE GENERATED THROUGH AN ASSESSMENT ON HOSPITALS AND CONTRIBUTIONS FROM MCOS, CCOS, PSHPs AND OTHER SUCH ORGANIZATIONS IN THE FORM OF AN ASSESSMENT AS PROVIDED IN THIS ACT; TO PROVIDE IF THE WAIVER AS DESCRIBED IN THIS ACT IS NOT SUBSTANTIALLY APPROVED BEFORE SEPTEMBER 30, 2024, OR IF THE WAIVER IS APPROVED BUT IS SUBSEQUENTLY TERMINATED, THEN THE DIVISION SHALL ALLOW FOR MEDICAID COVERAGE IN MISSISSIPPI FOR INDIVIDUALS DESCRIBED IN THE FEDERAL AFFORDABLE CARE ACT, TO BE KNOWN AS THE HEALTHY MISSISSIPPI WORKS (HMW) CATEGORY OF ELIGIBILITY, AND SHALL MOVE WITH ALL DELIBERATE SPEED TO SUBMIT THE REQUIRED STATE PLAN AMENDMENTS TO EFFECTUATE MEDICAID COVERAGE FOR THOSE INDIVIDUALS; TO PROVIDE THAT THE COVERAGE GROUP, DELIVERY SYSTEMS, BENEFIT PACKAGES AND FUNDING OF THE HMW CATEGORY OF ELIGIBILITY WILL BE SUBSTANTIALLY THE SAME AS THOSE IN THE WAIVER PLAN; TO PROVIDE FOR THE LEVY OF AN ASSESSMENT UPON EACH MANAGED CARE ORGANIZATION, COORDINATED CARE ORGANIZATION, PROVIDER SPONSORED HEALTH PLAN OR OTHER ORGANIZATION PAID FOR SERVICES ON A CAPITATED BASIS BY THE DIVISION, IN THE AMOUNT OF FOUR PERCENT ON THE TOTAL PAID CAPITATION, EXCLUDING ANY SUCH PAID AMOUNT THAT IS ATTRIBUTABLE TO SUPPLEMENTAL PAYMENTS; TO AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972, TO CONFORM TO THE PRECEDING PROVISIONS; TO PROVIDE THAT ALL OF THE PROVISIONS OF THIS ACT SHALL STAND REPEALED ON JANUARY 31, 2029; AND FOR RELATED PURPOSES.

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

SECTION 1. (1) The Office of the Governor, Division of Medicaid shall enter into negotiations with the Centers for Medicare and Medicaid Services (CMS) to obtain a waiver of applicable provisions of the Medicaid laws and regulations under Section 1115 of the Social Security Act to create a plan to allow...
Medicaid coverage in Mississippi for individuals described in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act as described in the federal Affordable Care Act and as eligible under this act, to be known as Healthy Mississippi Works (HMW), which contains the following provisions:

(a) **Coverage group.** Individuals eligible for coverage under HMW shall be persons who are not less than nineteen (19) years of age but less than sixty-five (65) years of age, who currently reside in households that have an income of not more than one hundred thirty-eight percent (138%) of federal poverty level or as otherwise described in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act and, to the extent approved by CMS in the Section 1115 waiver, who are employed for at least twenty (20) hours per week in a position for which health insurance is not provided by the employer or enrolled as a full-time student in secondary or post-secondary education or enrolled full-time in a workforce training program. Any individual otherwise eligible for coverage under HMW who has health insurance coverage through his or her employer or through private health insurance and who voluntarily disenrolls from that health insurance coverage shall not be in the coverage group until twelve (12) months after the ending date of that coverage. The coverage group shall not include non-United States citizens who are ineligible for Medicaid benefits.
(b) **Delivery systems.** All individuals in the coverage group shall be enrolled in and their services shall be provided by the managed care organizations (MCOs), coordinated care organizations (CCOs), provider-sponsored health plans (PSHPs) and other such organizations paid for services to the Medicaid population on a capitated basis by the division as described in Section 43-13-117(H).

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

(d) **Benefit packages.** (i) Individuals in the coverage group enrolled under HMW who are not less than nineteen (19) years of age but less than twenty-one (21) years of age will receive all Early and Periodic, Screening, Diagnosis and Treatment program (EPSDT) benefits to which they may be entitled under federal law and regulation. Individuals enrolled under HMW who are not less than twenty-one (21) years of age but less than sixty-five (65) years of age will have access to the state plan benefit package for adults eligible under Section 1902(a)(10)(A)(i)(VIII) of the
Social Security Act and as described by the Division of Medicaid and approved by CMS.

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

(e) Funding of the plan. (i) The Section 1115 waiver described in this section shall describe the funding for HMW, which shall be a combination of state matching funds and federal matching funds in the proportions specified under the federal Affordable Care Act at the time of the effective date of this act. (ii) If the federal matching fund proportion for medical services provided to the HMW population ever falls below
ninety percent (90%), the waiver for HMW shall be discontinued to coincide with the effective date of such a decrease in the federal matching fund proportion or as close to that date as required in order for the division to comply with any federal notice and due process requirements.

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

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

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

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

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

(a) Coverage group. Individuals eligible for coverage under the HMW category of eligibility shall be persons who are not less than nineteen (19) years of age but less than sixty-five (65) years of age, who currently reside in households that have an income of not more than one hundred thirty-eight percent (138%) of federal poverty level or as otherwise described in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act. Any individual otherwise eligible for coverage under HMW who has health insurance coverage through his or her employer or through
private health insurance and who voluntarily disenrolls from that
health insurance coverage shall not be in the coverage group until
twelve (12) months after the ending date of that coverage. The
coverage group shall not include non-United States citizens who
are ineligible for Medicaid benefits.

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

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

(d) **Benefit packages.** (i) Individuals in the coverage
group who are not less than nineteen (19) years of age but less
than twenty-one (21) years of age will receive all Early and
Periodic, Screening, Diagnosis and Treatment program (EPSDT)
benefits to which they may be entitled under federal law and
regulation. Individuals in the coverage group who are not less than twenty-one (21) years of age but less than sixty-five (65) years of age will have access to the state plan benefit package for adults eligible under Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act and as described by the Division of Medicaid and approved by CMS.

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

(e) Funding of the plan. (i) Funding for the HMW category of eligibility shall be a combination of state matching funds and federal matching funds in the proportions specified
under the federal Affordable Care Act at the time of the effective
date of this act.

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

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

(iv) The division is also authorized to accept any
voluntary contributions donated to the division to be used as
state matching funds for the HMW category of eligibility,
including, but not limited to, contributions from businesses and
other entities. Notwithstanding any provision of this paragraph
(e), state matching funds for the HMW category of eligibility may
be appropriated by the Legislature from any other sources.
This section shall stand repealed on January 31, 2029.

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

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

SECTION 4. 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 described in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act who are eligible under either Section 1 or Section 2 of this act, provided that the federal matching funds percentage for medical services provided for this category of individuals does not fall below ninety percent (90%). If the federal matching funds percentage for medical services falls below ninety percent (90%), then the division's coverage of these individuals shall be discontinued as expeditiously as possible pursuant to federal law. This paragraph (29) shall stand repealed on January 31, 2029.

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 5. If any section, paragraph, sentence, clause, phrase or any part of this act is declared to be unconstitutional or void, or if for any reason is declared to be invalid or of no
SECTION 6. This act shall take effect and be in force from and after its passage.