

By: Representative Johnson

To: Medicaid; Appropriations  
A

## HOUSE BILL NO. 125

1       AN ACT TO BE KNOWN AS THE MISSISSIPPI HEALTH CARE SECURITY  
2 AND PROMOTION ACT OF 2025; TO EXPRESS THE INTENT OF THE  
3 LEGISLATURE REGARDING EXPANSION OF THE MEDICAID PROGRAM; TO  
4 PROVIDE DEFINITIONS FOR THE PURPOSES OF THIS ACT; TO PROVIDE THAT  
5 ANY EXPANSION OF THE MEDICAID PROGRAM AND ITS ELIGIBILITY CRITERIA  
6 OR COVERED BENEFITS SHALL FALL INTO THE CATEGORIES OUTLINED IN  
7 THIS ACT AND BE DEFINED BY THE SECTIONS IN THIS ACT; TO DIRECT THE  
8 DIVISION OF MEDICAID TO SUBMIT TO THE CENTERS FOR MEDICARE AND  
9 MEDICAID SERVICES (CMS) AN APPLICATION FOR A WAIVER OR STATE PLAN  
10 AMENDMENT THAT WILL ALLOW THE DIVISION TO EXPAND COVERAGE TO  
11 ELIGIBLE INDIVIDUALS WHOSE INCOME IS AT OR BELOW 100% OF THE  
12 FEDERAL POVERTY LEVEL; TO DIRECT THE DIVISION TO SUBMIT TO CMS A  
13 REQUEST FOR A SECTION 1115 WAIVER THAT WILL ALLOW THE DIVISION TO  
14 EXPAND COVERAGE TO ELIGIBLE INDIVIDUALS WHO ARE UNINSURED AND  
15 WHOSE INCOME IS NOT LESS THAN 101% OR MORE THAN 200% OF THE  
16 FEDERAL POVERTY LEVEL; TO PROVIDE THAT UNINSURED INDIVIDUALS WITH  
17 TOTAL HOUSEHOLD INCOME OF NOT LESS THAN 101% OR MORE THAN 200% OF  
18 THE FEDERAL POVERTY LEVEL SHALL BE ELIGIBLE FOR EXPANDED COVERAGE  
19 THROUGH AN INDIVIDUAL QUALIFIED HEALTH INSURANCE PLAN; TO PROVIDE  
20 THAT INDIVIDUALS WITH CURRENT EMPLOYER HEALTH INSURANCE COVERAGE  
21 AND UNINSURED INDIVIDUALS WHO ARE OFFERED EMPLOYER HEALTH  
22 INSURANCE COVERAGE WITH TOTAL HOUSEHOLD INCOMES OF NOT LESS THAN  
23 101% OR MORE THAN 200% OF THE FEDERAL POVERTY LEVEL SHALL BE  
24 ELIGIBLE FOR PREMIUM ASSISTANCE FOR EMPLOYER HEALTH INSURANCE  
25 COVERAGE; TO PROVIDE THAT UPON CMS APPROVAL OF REQUESTED WAIVERS  
26 OR AMENDMENTS, THE DIVISION SHALL, IN CONJUNCTION AND CONSULTATION  
27 WITH RELATED STATE AGENCIES, IMPLEMENT THE APPROVED WAIVER  
28 COMPONENTS TO EXPAND ELIGIBILITY CRITERIA FOR THE MEDICAID PROGRAM  
29 AS PROVIDED UNDER THE APPLICABLE WAIVER; TO PROVIDE THAT  
30 ELIGIBILITY FOR MEDICAID AS DESCRIBED IN THIS ACT SHALL NOT BE  
31 DELAYED IF CMS FAILS TO APPROVE ANY REQUESTED WAIVERS OF THE STATE  
32 PLAN FOR WHICH THE DIVISION APPLIES, AND SUCH ELIGIBILITY SHALL  
33 NOT BE DELAYED WHILE THE DIVISION IS CONSIDERING OR NEGOTIATING  
34 ANY WAIVERS TO THE STATE PLAN; TO PROVIDE THAT IF CMS HAS NOT

35 APPROVED A REQUESTED WAIVER OR STATE PLAN AMENDMENT SUBMITTED BY  
36 THE DIVISION ON OR BEFORE DECEMBER 31, 20256, ELIGIBILITY FOR THE  
37 MEDICAID PROGRAM SHALL BE EXPANDED TO INCLUDE ALL ELIGIBLE  
38 POPULATIONS AND ESSENTIAL HEALTH BENEFITS AS PROVIDED IN THE  
39 FEDERAL PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010; TO  
40 AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972, TO CONFORM TO  
41 THE PRECEDING PROVISIONS; AND FOR RELATED PURPOSES.

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

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

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

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

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

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

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



- 64 (e) Strengthens the financial stability of the critical  
65 access hospitals and other small, rural hospitals;
- 66 (f) Fills gaps in the continuum of care for individuals  
67 in target populations in need of services;
- 68 (g) Addresses health-related social needs of  
69 Mississippians and reduces the additional risk for disease and  
70 premature death associated with those needs;
- 71 (h) Strengthens the ability of individuals to improve  
72 their economic security;
- 73 (i) Strengthens the ability of employers to recruit and  
74 retain productive employees;
- 75 (j) Encourages personal responsibility for individuals  
76 to understand their roles and obligations in maintaining private  
77 insurance coverage; and
- 78 (k) Ensures state responsibility and accountability for  
79 the administration of Medicaid health plans.

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

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

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

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



89 of the Social Security Act, 42 USC Section  
90 1396a(a)(10)(A)(i)(VII).

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

95 (e) "Health insurance benefit plan" means a policy,  
96 contract, certificate, or agreement offered or issued by a health  
97 insurer to provide, deliver, arrange for, pay for, or reimburse  
98 any of the costs of health care services, but not including  
99 excepted benefits as defined under 42 USC Section 300gg-91(c), as  
100 it existed on January 1, 2025.

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

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

110 (i) An insurance company;  
111 (ii) A medical services plan;  
112 (iii) A hospital plan;  
113 (iv) A hospital medical service corporation;

- (v) A health maintenance organization;
- (vi) A fraternal benefits society;
- (vii) Employer health insurance coverage;
- (viii) A managed care organization contracted with  
Coordinated Access Network; and
- (ix) Any other entity providing health insurance  
benefit plan subject to state regulation.

121 (h) "Health care coverage" means coverage provided  
122 through either an individual qualified health insurance plan, a  
123 managed care organization, an employer health insurance coverage,  
124 the Division of Medicaid's fee-for-service program, or the  
125 Division of Medicaid's managed care program, the Mississippi  
126 Coordinated Access Network.

127 (i) "Individual qualified health insurance plan" means  
128 an individual health insurance benefit plan offered by a health  
129 insurer that participates in the health insurance marketplace to  
130 provide coverage in Mississippi that covers essential health  
131 benefits as defined by the 45 CFR Section 156.110 and any federal  
132 insurance regulations, as they existed on January 1, 2025.

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



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

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

147 **SECTION 5. Medicaid program expansion.** (1) The Division of  
148 Medicaid shall develop an application for any federal waiver,  
149 state plan amendment, or other authority necessary to expand  
150 eligibility criteria for the Medicaid program. Before submitting  
151 the application to CMS, the Division of Medicaid shall report the  
152 application to the House and Senate Medicaid Committees for review  
153 and recommendations. On or before December 31, 2025, the Division  
154 of Medicaid shall submit to CMS an application for a waiver or  
155 state plan amendment that will, upon approval, allow the division  
156 to:

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



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

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

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

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

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

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

1. Benefits navigation;
2. Social and community resource navigation;
3. Community health workers.

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



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

188 SECTION 6. Expansion of the eligibility criteria for public  
189 health insurance coverage with Section 1115 waiver program. (1)

190 The Division of Medicaid shall develop an application for any  
191 federal waiver, state plan amendment, or other authority necessary  
192 to create and establish the Employer Health Insurance Coverage  
193 Premium Assistance Program. Before submission of the application  
194 to CMS, the Division of Medicaid shall report the application to  
195 the House and Senate Medicaid Committees for review and  
196 recommendations. On or before December 31, 2025, the Division of  
197 Medicaid shall submit to CMS an application for a Section 1115  
198 waiver that will, upon approval, allow the division to:

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

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

205 (i) Reducing improper use of emergency  
206 departments;

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



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

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

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

215 (c) Provide essential health benefits as defined under  
216 45 CFR Section 156.110 through:

217 (i) An individual qualified health insurance plan;  
218 or

219 (ii) Employer health insurance coverage.

220 (d) Provide for twelve (12) months of continuous  
221 enrollment that shall not be terminated due to procedural reasons;  
222 (e) Obtain maximum federal financial participation  
223 under 42 USC Section 1396d(y) or 42 USC Section 1396d(ii), as  
224 allowed, for enrolling an individual as a member of the Section  
225 1115 waiver program;

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

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

232 (3) Upon CMS approval of requested waivers or amendments,  
233 the division shall, in conjunction and consultation with related



234 state agencies, implement the waiver program to expand eligibility  
235 criteria and covered services of the program.

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

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

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

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

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

256 (ii) For individuals whose income is not less than  
257 one hundred fifty-one percent (151%) or more than one hundred

258 seventy-five percent (175%) of the federal poverty level: the  
259 division pays seventy-five percent (75%) of the premium.

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

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

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

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

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

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

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

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

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

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

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

302 (i) The level of the plan:

303 (ii) The amounts of allowable premiums:

304 (iii) Cost-sharing; and

#### 305 (iv) Auto-assignment methodology.

306 (b) Ensure that:



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

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

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

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

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

(4) Insurance coverage for a member enrolled in an individual qualified health insurance plan shall be obtained, at a minimum, through silver-level metallic plans as provided in 42 USC Section 18022(d) and Section 18071, as they existed on January 1, 2025, that restrict out-of-pocket costs to amounts that do not exceed applicable out-of-pocket cost limitations.

(5) The Division of Medicaid, Department of Insurance, and each of the individual qualified health insurance plans shall enter into a memorandum of understanding that shall specify the duties and obligations of each party in the operation of the



332 Section 1115 waiver program at least thirty (30) calendar days  
333 before the annual open enrollment period. The memorandums of  
334 understanding shall include provisions necessary to effectuate the  
335 purchasing guidelines and reporting requirements including,  
336 without limitation, that:

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

342 (b) Health insurer plans maintain a medical-loss ratio  
343 of at least eighty percent (80%) as required under 45 CFR Section  
344 158.210(c), as it existed on January 1, 2025, or rebate the  
345 difference to the division for those enrolled;

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

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

356                   **SECTION 8. Expanded coverage through employer health**

357                   **insurance premium assistance.** (1) Individuals with current  
358 employer health insurance coverage and uninsured individuals who  
359 are offered employer health insurance coverage with total  
360 household incomes of not less than one hundred one percent (101%)  
361 or more than two hundred percent (200%) of the federal poverty  
362 level shall be eligible for premium assistance for employer health  
363 insurance coverage.

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

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

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

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

379                   (iii) For individuals whose income is not less  
380 than one hundred seventy-six percent (176%) or more than two



381 hundred percent (200%) of the federal poverty level: the division  
382 pays fifty percent (50%) of the premium.

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

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

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

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

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

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

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

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

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

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

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

417 (4) The division shall ensure that the group health  
418 insurance plan being offered is, at minimum, through silver-level  
419 metallic plans as provided in 42 USC Section 18022(d) and Section  
420 18071, as they existed on January 1, 2025, that restrict  
421 out-of-pocket costs to amounts that do not exceed applicable  
422 out-of-pocket cost limitations.

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



430 guidelines and reporting requirements including, without  
431 limitation, that:

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

437 (b) Health insurer plans maintain a medical-loss ratio  
438 of at least eighty percent (80%) as required under 45 CFR Section  
439 158.210(c), as it existed on January 1, 2025, or rebate the  
440 difference to the division for those enrolled;

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

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

451 **SECTION 9. Implementation and enforcement of the act.** (1)

452 Eligibility for Medicaid as described in this act shall not be  
453 delayed if CMS fails to approve any requested waivers of the state  
454 plan for which the division applies, and such eligibility shall



455 not be delayed while the division is considering or negotiating  
456 any waivers to the state plan.

457 (2) If CMS has not approved a requested waiver or state plan  
458 amendment submitted by the division on or before December 31,  
459 2026, eligibility for the Medicaid program shall be expanded to  
460 include all eligible populations and essential health benefits as  
461 provided in the Federal Patient Protection and Affordable Care Act  
462 of 2010, as amended.

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

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

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

480           43-13-115. Recipients of Medicaid shall be the following  
481 persons only:

482           (1) Those who are qualified for public assistance  
483 grants under provisions of Title IV-A and E of the federal Social  
484 Security Act, as amended, including those statutorily deemed to be  
485 IV-A and low income families and children under Section 1931 of  
486 the federal Social Security Act. For the purposes of this  
487 paragraph (1) and paragraphs (8), (17) and (18) of this section,  
488 any reference to Title IV-A or to Part A of Title IV of the  
489 federal Social Security Act, as amended, or the state plan under  
490 Title IV-A or Part A of Title IV, shall be considered as a  
491 reference to Title IV-A of the federal Social Security Act, as  
492 amended, and the state plan under Title IV-A, including the income  
493 and resource standards and methodologies under Title IV-A and the  
494 state plan, as they existed on July 16, 1996. The Department of  
495 Human Services shall determine Medicaid eligibility for children  
496 receiving public assistance grants under Title IV-E. The division  
497 shall determine eligibility for low income families under Section  
498 1931 of the federal Social Security Act and shall redetermine  
499 eligibility for those continuing under Title IV-A grants.

500           (2) Those qualified for Supplemental Security Income  
501 (SSI) benefits under Title XVI of the federal Social Security Act,  
502 as amended, and those who are deemed SSI eligible as contained in  
503 federal statute. The eligibility of individuals covered in this

504 paragraph shall be determined by the Social Security  
505 Administration and certified to the Division of Medicaid.

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

511 (4) [Deleted]

512 (5) A child born on or after October 1, 1984, to a  
513 woman eligible for and receiving Medicaid under the state plan on  
514 the date of the child's birth shall be deemed to have applied for  
515 Medicaid and to have been found eligible for Medicaid under the  
516 plan on the date of that birth, and will remain eligible for  
517 Medicaid for a period of one (1) year so long as the child is a  
518 member of the woman's household and the woman remains eligible for  
519 Medicaid or would be eligible for Medicaid if pregnant. The  
520 eligibility of individuals covered in this paragraph shall be  
521 determined by the Division of Medicaid.

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



529     eligibility of the children covered under this paragraph shall be  
530     determined by the State Department of Human Services.

531                 (7) Persons certified by the Division of Medicaid who  
532     are patients in a medical facility (nursing home, hospital,  
533     tuberculosis sanatorium or institution for treatment of mental  
534     diseases), and who, except for the fact that they are patients in  
535     that medical facility, would qualify for grants under Title IV,  
536     Supplementary Security Income (SSI) benefits under Title XVI or  
537     state supplements, and those aged, blind and disabled persons who  
538     would not be eligible for Supplemental Security Income (SSI)  
539     benefits under Title XVI or state supplements if they were not  
540     institutionalized in a medical facility but whose income is below  
541     the maximum standard set by the Division of Medicaid, which  
542     standard shall not exceed that prescribed by federal regulation.

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

549                 (9) Individuals who are:

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



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

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

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

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

573 (11) Until the end of the day on December 31, 2005,  
574 individuals who are sixty-five (65) years of age or older or are  
575 disabled as determined under Section 1614(a)(3) of the federal  
576 Social Security Act, as amended, and whose income does not exceed  
577 one hundred thirty-five percent (135%) of the nonfarm official  
578 poverty level as defined by the Office of Management and Budget



579 and revised annually, and whose resources do not exceed those  
580 established by the Division of Medicaid. The eligibility of  
581 individuals covered under this paragraph shall be determined by  
582 the Division of Medicaid. After December 31, 2005, only those  
583 individuals covered under the 1115(c) Healthier Mississippi waiver  
584 will be covered under this category.

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

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

602 The eligibility of individuals covered under this paragraph  
603 shall be determined by the Division of Medicaid, and those

604 individuals determined eligible shall receive Medicare  
605 cost-sharing expenses only as more fully defined by the Medicare  
606 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of  
607 1997.

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

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

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

626 (14) [Deleted]

627 (15) Disabled workers who are eligible to enroll in  
628 Part A Medicare as required by Public Law 101-239, known as the

629 Omnibus Budget Reconciliation Act of 1989, and whose income does  
630 not exceed two hundred percent (200%) of the federal poverty level  
631 as determined in accordance with the Supplemental Security Income  
632 (SSI) program. The eligibility of individuals covered under this  
633 paragraph shall be determined by the Division of Medicaid and  
634 those individuals shall be entitled to buy-in coverage of Medicare  
635 Part A premiums only under the provisions of this paragraph (15).

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

642 (17) In accordance with the terms of the federal  
643 Personal Responsibility and Work Opportunity Reconciliation Act of  
644 1996 (Public Law 104-193), persons who become ineligible for  
645 assistance under Title IV-A of the federal Social Security Act, as  
646 amended, because of increased income from or hours of employment  
647 of the caretaker relative or because of the expiration of the  
648 applicable earned income disregards, who were eligible for  
649 Medicaid for at least three (3) of the six (6) months preceding  
650 the month in which the ineligibility begins, shall be eligible for  
651 Medicaid for up to twelve (12) months. The eligibility of the  
652 individuals covered under this paragraph shall be determined by  
653 the division.



654 (18) Persons who become ineligible for assistance under  
655 Title IV-A of the federal Social Security Act, as amended, as a  
656 result, in whole or in part, of the collection or increased  
657 collection of child or spousal support under Title IV-D of the  
658 federal Social Security Act, as amended, who were eligible for  
659 Medicaid for at least three (3) of the six (6) months immediately  
660 preceding the month in which the ineligibility begins, shall be  
661 eligible for Medicaid for an additional four (4) months beginning  
662 with the month in which the ineligibility begins. The eligibility  
663 of the individuals covered under this paragraph shall be  
664 determined by the division.

665 (19) Disabled workers, whose incomes are above the  
666 Medicaid eligibility limits, but below two hundred fifty percent  
667 (250%) of the federal poverty level, shall be allowed to purchase  
668 Medicaid coverage on a sliding fee scale developed by the Division  
669 of Medicaid.

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

675 (21) Women of childbearing age whose family income does  
676 not exceed one hundred eighty-five percent (185%) of the federal  
677 poverty level. The eligibility of individuals covered under this  
678 paragraph (21) shall be determined by the Division of Medicaid,



679 and those individuals determined eligible shall only receive  
680 family planning services covered under Section 43-13-117(13) and  
681 not any other services covered under Medicaid. However, any  
682 individual eligible under this paragraph (21) who is also eligible  
683 under any other provision of this section shall receive the  
684 benefits to which he or she is entitled under that other  
685 provision, in addition to family planning services covered under  
686 Section 43-13-117(13) .

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

695           (22) Persons who are workers with a potentially severe  
696 disability, as determined by the division, shall be allowed to  
697 purchase Medicaid coverage. The term "worker with a potentially  
698 severe disability" means a person who is at least sixteen (16)  
699 years of age but under sixty-five (65) years of age, who has a  
700 physical or mental impairment that is reasonably expected to cause  
701 the person to become blind or disabled as defined under Section  
702 1614(a) of the federal Social Security Act, as amended, if the



703 person does not receive items and services provided under  
704 Medicaid.

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

712 (23) Children certified by the Mississippi Department  
713 of Human Services for whom the state and county departments of  
714 human services have custody and financial responsibility who are  
715 in foster care on their eighteenth birthday as reported by the  
716 Mississippi Department of Human Services shall be certified  
717 Medicaid eligible by the Division of Medicaid until their  
718 twenty-first birthday.

719 (24) Individuals who have not attained age sixty-five  
720 (65), are not otherwise covered by creditable coverage as defined  
721 in the Public Health Services Act, and have been screened for  
722 breast and cervical cancer under the Centers for Disease Control  
723 and Prevention Breast and Cervical Cancer Early Detection Program  
724 established under Title XV of the Public Health Service Act in  
725 accordance with the requirements of that act and who need  
726 treatment for breast or cervical cancer. Eligibility of

727 individuals under this paragraph (24) shall be determined by the  
728 Division of Medicaid.

729 (25) The division shall apply to the Centers for  
730 Medicare and Medicaid Services (CMS) for any necessary waivers to  
731 provide services to individuals who are sixty-five (65) years of  
732 age or older or are disabled as determined under Section  
733 1614(a)(3) of the federal Social Security Act, as amended, and  
734 whose income does not exceed one hundred thirty-five percent  
735 (135%) of the nonfarm official poverty level as defined by the  
736 Office of Management and Budget and revised annually, and whose  
737 resources do not exceed those established by the Division of  
738 Medicaid, and who are not otherwise covered by Medicare. Nothing  
739 contained in this paragraph (25) shall entitle an individual to  
740 benefits. The eligibility of individuals covered under this  
741 paragraph shall be determined by the Division of Medicaid.

742 (26) The division shall apply to the Centers for  
743 Medicare and Medicaid Services (CMS) for any necessary waivers to  
744 provide services to individuals who are sixty-five (65) years of  
745 age or older or are disabled as determined under Section  
746 1614(a)(3) of the federal Social Security Act, as amended, who are  
747 end stage renal disease patients on dialysis, cancer patients on  
748 chemotherapy or organ transplant recipients on antirejection  
749 drugs, whose income does not exceed one hundred thirty-five  
750 percent (135%) of the nonfarm official poverty level as defined by  
751 the Office of Management and Budget and revised annually, and



752 whose resources do not exceed those established by the division.  
753 Nothing contained in this paragraph (26) shall entitle an  
754 individual to benefits. The eligibility of individuals covered  
755 under this paragraph shall be determined by the Division of  
756 Medicaid.

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

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

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

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

774 **SECTION 11.** This act shall take effect and be in force from  
775 and after July 1, 2025.

