

By: Representatives Johnson, Porter, Clark,
Hines

To: Medicaid; Appropriations
A

HOUSE BILL NO. 1146

1 AN ACT TO BE KNOWN AS THE MISSISSIPPI HEALTH CARE SECURITY
2 AND PROMOTION ACT OF 2024; 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, 2025, 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, 2024.

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;



114 (v) A health maintenance organization;
115 (vi) A fraternal benefits society;
116 (vii) Employer health insurance coverage;
117 (viii) A managed care organization contracted with
118 the Mississippi Coordinated Access Network; and
119 (ix) Any other entity providing health insurance
120 or a 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.

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

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

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



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

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

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

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



162 (c) Provide essential health benefits as defined under
163 45 CFR Section 156.110 through the state's Medicaid managed care
164 program, the Mississippi Coordinated Access Network;

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

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

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

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

- 176 1. Benefits navigation;
177 2. Social and community resource navigation;
178 3. Community health workers.

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

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



187 **SECTION 6. Expansion of the eligibility criteria for public**

188 **health insurance coverage with Section 1115 waiver program. (1)**

189 The Division of Medicaid shall develop an application for any
190 federal waiver, state plan amendment, or other authority necessary
191 to create and establish the Employer Health Insurance Coverage
192 Premium Assistance Program. Before submission of the application
193 to CMS, the Division of Medicaid shall report the application to
194 the House and Senate Medicaid Committees for review and
195 recommendations. On or before December 31, 2024, the Division of
196 Medicaid shall submit to CMS an application for a Section 1115
197 Waiver that will, upon approval, allow the Division to:

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

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

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

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

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

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



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

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

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

218 (ii) Employer health insurance coverage.

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

221 (e) Obtain maximum federal financial participation
222 under 42 USC Section 1396d(y) or 42 USC Section 1396d(ii), as
223 allowed, for enrolling an individual as a member of the Section
224 1115 waiver program;

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

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

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



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

238 **SECTION 7. Expanded coverage through an individual qualified**

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

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

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

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

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



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

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

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

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

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

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

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

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



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

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

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

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

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

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

- 301 (i) The level of the plan;
302 (ii) The amounts of allowable premiums;
303 (iii) Cost-sharing; and
304 (iv) Auto-assignment methodology.

305 (b) Ensure that:

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



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

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

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

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

321 (4) Insurance coverage for a member enrolled in an
322 individual qualified health insurance plan shall be obtained, at a
323 minimum, through silver-level metallic plans as provided in 42 USC
324 Section 18022(d) and Section 18071, as they existed on January 1,
325 2024, that restrict out-of-pocket costs to amounts that do not
326 exceed applicable out-of-pocket cost limitations.

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



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

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

341 (b) Health insurers plans maintain a medical-loss ratio
342 of at least eighty percent (80%) as required under 45 CFR Section
343 158.210(c), as it existed on January 1, 2024, or rebate the
344 difference to the division for those enrolled;

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

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

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



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

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

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

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

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

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

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



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

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

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

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

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

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

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

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



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

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

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

416 (4) The division shall ensure that the group health
417 insurance plan being offered is, at minimum, through silver-level
418 metallic plans as provided in 42 USC Section 18022(d) and Section
419 18071, as they existed on January 1, 2024, that restrict
420 out-of-pocket costs to amounts that do not exceed applicable
421 out-of-pocket cost limitations.

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

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



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

436 (b) Health insurers plans maintain a medical-loss ratio
437 of at least eighty percent (80%) as required under 45 CFR Section
438 158.210(c), as it existed on January 1, 2024, or rebate the
439 difference to the division for those enrolled;

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

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

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

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

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



458 2025, eligibility for the Medicaid program shall be expanded to
459 include all eligible populations and essential health benefits as
460 provided in the Federal Patient Protection and Affordable Care Act
461 of 2010, as amended.

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

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

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

479 43-13-115. Recipients of Medicaid shall be the following
480 persons only:

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



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

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

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



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

510 (4) [Deleted]

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

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

530 (7) Persons certified by the Division of Medicaid who
531 are patients in a medical facility (nursing home, hospital,
532 tuberculosis sanatorium or institution for treatment of mental



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

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

548 (9) Individuals who are:

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

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



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

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

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

572 (11) Until the end of the day on December 31, 2005,
573 individuals who are sixty-five (65) years of age or older or are
574 disabled as determined under Section 1614(a)(3) of the federal
575 Social Security Act, as amended, and whose income does not exceed
576 one hundred thirty-five percent (135%) of the nonfarm official
577 poverty level as defined by the Office of Management and Budget
578 and revised annually, and whose resources do not exceed those
579 established by the Division of Medicaid. The eligibility of
580 individuals covered under this paragraph shall be determined by
581 the Division of Medicaid. After December 31, 2005, only those



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

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

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

601 The eligibility of individuals covered under this paragraph
602 shall be determined by the Division of Medicaid, and those
603 individuals determined eligible shall receive Medicare
604 cost-sharing expenses only as more fully defined by the Medicare
605 Catastrophic Coverage Act of 1988 and the Balanced Budget Act of
606 1997.



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

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

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

625 (14) [Deleted]

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



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

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

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

653 (18) Persons who become ineligible for assistance under
654 Title IV-A of the federal Social Security Act, as amended, as a
655 result, in whole or in part, of the collection or increased
656 collection of child or spousal support under Title IV-D of the



657 federal Social Security Act, as amended, who were eligible for
658 Medicaid for at least three (3) of the six (6) months immediately
659 preceding the month in which the ineligibility begins, shall be
660 eligible for Medicaid for an additional four (4) months beginning
661 with the month in which the ineligibility begins. The eligibility
662 of the individuals covered under this paragraph shall be
663 determined by the division.

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

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

674 (21) Women of childbearing age whose family income does
675 not exceed one hundred eighty-five percent (185%) of the federal
676 poverty level. The eligibility of individuals covered under this
677 paragraph (21) shall be determined by the Division of Medicaid,
678 and those individuals determined eligible shall only receive
679 family planning services covered under Section 43-13-117(13) and
680 not any other services covered under Medicaid. However, any
681 individual eligible under this paragraph (21) who is also eligible



682 under any other provision of this section shall receive the
683 benefits to which he or she is entitled under that other
684 provision, in addition to family planning services covered under
685 Section 43-13-117(13).

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

694 (22) Persons who are workers with a potentially severe
695 disability, as determined by the division, shall be allowed to
696 purchase Medicaid coverage. The term "worker with a potentially
697 severe disability" means a person who is at least sixteen (16)
698 years of age but under sixty-five (65) years of age, who has a
699 physical or mental impairment that is reasonably expected to cause
700 the person to become blind or disabled as defined under Section
701 1614(a) of the federal Social Security Act, as amended, if the
702 person does not receive items and services provided under
703 Medicaid.

704 The eligibility of persons under this paragraph (22) shall be
705 conducted as a demonstration project that is consistent with
706 Section 204 of the Ticket to Work and Work Incentives Improvement



707 Act of 1999, Public Law 106-170, for a certain number of persons
708 as specified by the division. The eligibility of individuals
709 covered under this paragraph (22) shall be determined by the
710 Division of Medicaid.

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

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

728 (25) The division shall apply to the Centers for
729 Medicare and Medicaid Services (CMS) for any necessary waivers to
730 provide services to individuals who are sixty-five (65) years of
731 age or older or are disabled as determined under Section



732 1614(a)(3) of the federal Social Security Act, as amended, and
733 whose income does not exceed one hundred thirty-five percent
734 (135%) of the nonfarm official poverty level as defined by the
735 Office of Management and Budget and revised annually, and whose
736 resources do not exceed those established by the Division of
737 Medicaid, and who are not otherwise covered by Medicare. Nothing
738 contained in this paragraph (25) shall entitle an individual to
739 benefits. The eligibility of individuals covered under this
740 paragraph shall be determined by the Division of Medicaid.

741 (26) The division shall apply to the Centers for
742 Medicare and Medicaid Services (CMS) for any necessary waivers to
743 provide services to individuals who are sixty-five (65) years of
744 age or older or are disabled as determined under Section
745 1614(a)(3) of the federal Social Security Act, as amended, who are
746 end stage renal disease patients on dialysis, cancer patients on
747 chemotherapy or organ transplant recipients on antirejection
748 drugs, whose income does not exceed one hundred thirty-five
749 percent (135%) of the nonfarm official poverty level as defined by
750 the Office of Management and Budget and revised annually, and
751 whose resources do not exceed those established by the division.
752 Nothing contained in this paragraph (26) shall entitle an
753 individual to benefits. The eligibility of individuals covered
754 under this paragraph shall be determined by the Division of
755 Medicaid.



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

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

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

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

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

