MISSISSIPPI LEGISLATURE REGULAR SESSION 2020

By: Representatives Dortch, Bell (65th), Clarke, Williams-Barnes, Paden, Gibbs (72nd), Summers, Anthony, Clark, Crudup, Denton, Foster, Mickens, Rosebud, Yates

To: Medicaid; Appropriations

HOUSE BILL NO. 350

AN ACT TO DIRECT THE GOVERNOR AND 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 THE EXPANSION OF MEDICAID COVERAGE IN MISSISSIPPI WITH HEALTH CARE DELIVERY SYSTEM AND PAYMENT MODEL REFORM; TO PROVIDE THAT THE PLAN AND THE RESULTING MEDICAID PROGRAM SHALL BE KNOWN AS "ONE MISSISSIPPI"; TO SPECIFY THE PROVISIONS THAT THE GOVERNOR AND THE DIVISION SHALL SEEK TO HAVE INCLUDED IN THE WAIVER PLAN, WHICH INCLUDE THE OBJECTIVES AND STRUCTURE OF THE PLAN, SHARED SAVINGS PROGRAMS AND BENEFICIARIES; TO PROVIDE THAT UNDER THE PLAN, THE DIVISION SHALL ACCEPT ADDITIONAL FEDERAL MEDICAID REIMBURSEMENTS TO ESTABLISH AND FUND REGIONAL CARE ORGANIZATIONS; TO PROVIDE THAT PERSONS FROM NINETEEN TO SIXTY-FIVE YEARS OF AGE WHO CURRENTLY RESIDE IN HOUSEHOLDS THAT HAVE AN INCOME OF NOT MORE THAN 138% OF FEDERAL POVERTY LEVEL SHALL BE ELIGIBLE FOR COVERAGE UNDER THE PLAN; TO PROVIDE THAT IN SELECTING A SHARED SAVINGS PROGRAM, REGIONAL CARE ORGANIZATIONS MAY CHOOSE BETWEEN AN UPSIDE SHARING MODEL OR A RISK BASED, TWO-SIDED MODEL; TO PROVIDE THAT BENEFICIARIES SHALL OPT IN FOR COVERAGE WITH THE REGIONAL CARE ORGANIZATION'S PROVIDERS; TO PROVIDE THAT MEMBERS WITH INCOMES ABOVE FIFTY PERCENT OF THE FEDERAL POVERTY LEVEL SHALL PAY AN ANNUAL MEMBERSHIP FEE OF TWENTY-FIVE DOLLARS; TO PROVIDE THAT IF A WAIVER IS OBTAINED TO ALLOW THE EXPANSION OF MEDICAID COVERAGE, THE DIVISION SHALL AMEND THE STATE PLAN TO INCLUDE THE PROVISIONS AUTHORIZED IN THE WAIVER AND SHALL BEGIN IMPLEMENTING THE PLAN AUTHORIZED BY THE WAIVER; TO AMEND SECTION 43-13-115, MISSISSIPPI CODE OF 1972, TO CONFORM TO THE PRECEDING PROVISIONS; AND FOR RELATED PURPOSES.

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

SECTION 1. (1) The Governor and the 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 federal Social Security Act to create a plan to allow the expansion of Medicaid coverage in Mississippi with health care delivery system and payment model reform, which contains the following provisions:

(a) **Objectives.** The objectives of the plan are to:

(i) Improve coordination of care and move away from paying for volume to paying for value in health care services; and

(ii) Align with other payers to provide consistency in how providers are paid so that they can deliver consistent and quality care to all patients and effectuate changes needed in the health care system.

(b) **Structure.** (i) The plan and the resulting Medicaid program shall be known as "One Mississippi." Under One Mississippi, the division shall accept additional federal Medicaid reimbursements to establish and fund Regional Care Organizations.

(ii) 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 shall be eligible for coverage under the plan.

(iii) Regional Care Organizations (RCOs) are provider-led and/or insurer-led managed care systems that will ultimately provide health care services to most Medicaid enrollees

at an established cost under the supervision and approval of the division. Some of the services to be covered by RCOs include hospital inpatient and outpatient care, emergency room services, primary and specialty care, services provided by a federally qualified health center or rural health clinic, lab and radiology services, mental/behavioral health services, eye care and maternity care.

(iv) RCOs shall consist of a minimum of seventy-five percent (75%) of hospitals and primary care providers, each federally qualified health center, and each community mental health center within the RCO's defined region. The community mental health center and other RCO providers shall provide substance abuse treatment, including, but not limited to, treatment for opioid addictions.

(c) **Shared Savings Programs.** (i) In a shared savings program, the RCO provider network will still receive fee-for-service payments, but the network agrees to be tracked on total costs and quality of care for the patients it serves, in exchange for the opportunity to share in any savings achieved through better care management, and it can keep some savings if it meets or exceeds quality thresholds and the total payments are less than the amount that was projected at the beginning of the year. Provider participants in RCOs essentially have agreed that quality can be improved, and health care costs can be reduced, and they will work together toward that goal.

(ii) In selecting a shared savings program, RCOs may choose between two (2) sharing/risk tracks:

1. An upside sharing model, in which the RCO will be paid if the percentage of savings achieved exceeds a two percent (2%) to three and nine-tenths percent (3.9%) minimum savings rate (depending on the number of patients attributed to the RCO) of its trended benchmark; or

2. A risk based, two-sided model, where the RCO will share in any savings if the percentage of savings achieved exceeds a two percent (2%) minimum savings rate (MSR), but must also share in losses if the RCO's actual expenditures exceed the benchmark by more than two percent (2%).

In the two-sided model, the RCO is allowed to capture a greater percentage of shared savings, since it bears downside risk. Both tracks distribute "first dollar" savings, in which RCOs share in all savings achieved if those savings exceed the MSR (for example, if an RCO has a two percent (2%) MSR and achieves two and three-tenths percent (2.3%) savings, the savings are calculated based on a figure of two and three-tenths percent (2.3%), not the three-tenths of one percent (0.3%) above the MSR).

(iii) The division shall calculate a retrospective per member per month baseline spending calculation based on Medicaid claims/encounters provided in the RCO's designated area during the most recent three (3) years before the first year of the RCO program.

(d) **Beneficiaries.** (i) RCOs shall enroll beneficiaries (members) within their region in accordance with federal Medicaid requirements. Members shall have access to other RCOs outside of their home RCO, but the division shall partner with the RCO to encourage proper utilization of primary and preventive care within the home RCO's network.

(ii) Members shall opt in for coverage with the RCO's providers. Members with incomes above fifty percent (50%) of the federal poverty level shall pay an annual membership fee of Twenty-five Dollars ($25.00). Providers shall serve as assisters in the enrollment process and the RCOs shall partner with the state to perform annual eligibility redeterminations.

(2) If the Governor and the Division of Medicaid are successful in obtaining a Section 1115 waiver to allow the expansion of Medicaid coverage in Mississippi with health care delivery system and payment model reform as provided in subsection (1) of this section, the division shall amend the state plan to include the provisions authorized in the waiver, and shall begin implementing the plan authorized by the waiver after receiving CMS approval of the state plan amendment.

SECTION 2. 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) Individuals who are eligible under the Section 1115 waiver obtained under Section 1 of this act.

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 3. This act shall take effect and be in force from and after July 1, 2020.

ST: Medicaid; seek waiver for plan to expand eligibility with regional care organizations, known as "One Mississippi."