



MISSISSIPPI DIVISION OF  
**MEDICAID**

# **5-Year Strategic Plan for Fiscal Years 2019-2023**

**Mississippi Division of Medicaid**



**Legislative Budget Office**

## **Mission Statement**

The Mississippi Division of Medicaid responsibly provides access to quality health coverage for vulnerable Mississippians.

## **Statement of Purpose**

Medicaid provides health coverage for eligible, low income populations in Mississippi. These populations primarily include children, the aged and disabled, low-income parents/caretakers, and pregnant women. Eligible members do not directly receive money from Medicaid for health benefits. Enrolled and qualified Medicaid providers are reimbursed for health services they provide to eligible beneficiaries.

Medicaid is a state and federal program created by the Social Security Amendments of 1965 (PL 89-97), authorized by Title XIX of the Social Security Act to provide health coverage for eligible, low income populations. The Mississippi Division of Medicaid was enacted by the Mississippi Legislature in 1969. All 50 states, five territories of the United States and District of Columbia participate in this voluntary matching program.

The agency has approximately 1,000 employees located throughout one central office, 30 regional offices and over 80 outstations. Our employees are charged with administering multiple Medicaid health benefits programs to those who qualify.

## **Agency Philosophy**

### **Values and Principles**

The Mississippi Division of Medicaid is committed to accomplishing our mission by conducting agency operations with the following values: accountability, consistency and respect.

The agency strikes a fine balance of complying with state and federal requirements, collaborating with a variety of stakeholders to ensure access to quality medical services, being accountable to taxpayers, and doing so while providing excellent customer service.

## Relevant Statewide Goals and Benchmarks

### Statewide Goal #1: Health

To protect Mississippians from risks to public health and to provide them with the health-related information and access to quality healthcare necessary to increase the length and quality of their lives.

#### Relevant Benchmark #1: Access to care

- Percentage of Mississippi population under 19 years of age who are insured
- Preventable hospitalizations (discharge rate among the Medicare population for diagnoses amenable to non-hospital-based care)
- Number of persons treated in emergency rooms for non-emergency issues and costs, for Medicaid patients and for all patients
- Percentage of people receiving mental health crisis services who were treated at community mental health centers (versus in an institutional setting)
- Number of individuals on waiting list for home and community based services

#### Relevant Benchmark #1: Maternal and child health

- Births of low birthweight (less than 5 pounds, 8 ounces) as a percentage of all births
- Percentage of women who received prenatal care in the first trimester
- Percentage of live births delivered prior to 37 weeks of gestation
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) well-child screening rates for Medicaid and Children's Health Insurance Program (CHIP) children

#### Relevant Benchmark #1: Communicable disease

- Percentage of children fully immunized by 2-years of age
- Adolescent vaccination rates, by recommended vaccine [meningococcal; combined tetanus, diphtheria and pertussis (Tdap); human papillomavirus (HPV)]

#### Relevant Benchmark #1: Non-communicable disease

- Percentage of adults who are obese [defined as a Body Mass Index (BMI) of 30 or more, regardless of sex]
- Asthma hospitalization rate
- HEDIS measure for population with diabetes (HbA1c)

## **Statewide Goal #2: Human Services**

To ensure that Mississippians are able to develop to their full potential by having their basic needs met, including the need for adequate food, shelter and a healthy, stable and nurturing family environment or a competent and caring system of social support.

### **Relevant Benchmark #2: Social indicators**

- To understand the impact that the social determinants of health have on the health outcomes of Medicaid beneficiaries

## **Overview of the Agency 5-Year Strategic Plan**

The Mississippi Division of Medicaid (DOM) is responsible for providing access to quality health coverage for eligible beneficiaries. According to the U.S. Census Bureau, there are nearly three million residents in Mississippi as of July 2016, which translates to over 1 in 4 Mississippians who currently receive health benefits through regular fee-for-service Medicaid, the Children's Health Insurance Program (CHIP), and the Mississippi Coordinated Access Network (MississippiCAN), DOM's coordinated care program. As of June 30, 2017, 760,267 Mississippians were enrolled in Medicaid and CHIP. The largest population we serve is children, who comprise approximately 55 percent of our beneficiaries.

Although each state runs its own Medicaid program, the eligibility of beneficiaries is determined by household income and Supplemental Security Income (SSI) status, based on the Federal Poverty Level (FPL) and family size. FPL is set by the U.S. Department of Health and Human Services, and DOM is obliged to adhere to it. However, the federal government through the Centers for Medicare and Medicaid Services (CMS) supports state programs by matching their Medicaid costs at varying levels. This is called the Federal Medical Assistance Percentage (FMAP), and Mississippi currently has the highest FMAP in the country. The vast majority of Medicaid funds are used to reimburse providers for medical services they provide to Medicaid beneficiaries.

The largest expenditure to the agency (and state) is medical services costs for taking care of beneficiaries. Accordingly, the agency's goals are focused on finding innovative ways to make data-driven decisions to improve health outcomes, provide better care for beneficiaries, and develop efficient programs to allow for fiscal responsibility and lower per capita costs for the state.

Over the next five years, we will: Find innovative ways to make data-driven decisions to improve health outcomes, utilizing methods such as population health. Provide better care for beneficiaries through coordinated care, telehealth, and transition from case management to care management. Continue to refine our efficient programs to allow for fiscal responsibility and lower per capita costs for the state. The agency will specifically focus on efforts including, but not limited to:

- Increasing Home and Community Based Services.
- Ensuring compliance with all related federal, state, and contractual regulations.
- Developing internal training programs to recruit, train and retain employees.
- Attracting and maintaining a diverse, knowledgeable and dedicated agency workforce; identifying ways to reduce turnover.
- Improving the effectiveness and efficiency of the delivery of medical services, and explore innovative ways to impact health-care delivery and accessibility.
- Monitoring and collaborating with DOM's coordinated care organizations to improve health outcomes for beneficiaries enrolled in the coordinated care plans, and to ensure compliance with all related federal, state, and contractual regulations.
- Attracting and maintaining a strong network of providers.
- Incentivizing providers by reimbursing for outcomes and quality.
- Working with policy makers to improve access to care, improve health outcomes and reduce costs.
- Improving beneficiary health literacy and personal involvement in their health status.
- Continuing to improve and introduce up-to-date management information, communication systems and equipment.
- Strengthening procedures related to recovery of funds from audits, investigations and rate changes.
- Maximizing available program benefits by identifying ways to increase cost savings, eliminating duplication of services and using all sources of funds, including strategically utilizing matching funds.

As mentioned, we are continuously adjusting the Medicaid program to comply with changing regulations from federal agencies, most often from the Centers for Medicare and Medicaid Services (CMS), the Patient Protection and Affordable Care Act (PPACA) and modernization requirements for the DOM eligibility system and management information system. The PPACA has had a tremendous impact on DOM in terms of increased costs, regulatory burdens and administrative strains.

Over the next five years, technology costs will be increasing substantially to cover a replacement Medicaid Enterprise System (MES), implement an asset verification system as

mandated by the Medicaid and Human Services Transparency and Fraud Prevention Act, maintaining compliance with the Health Insurance Portability and Accountability Act (HIPAA), an updated Medicaid Information Technology Architecture (MITA) state self-assessment, staff costs to support all of these initiatives, as well as making changes to keep the current system compliant with the PPACA, CMS initiatives and technical system changes resulting from the program changes.

Additionally, the majority of Medicaid cost drivers and expenditures are contingent upon external influences, including, but not limited to: rising costs of medical services and pharmaceuticals, state and federal laws and regulations, utilization of services, changes in beneficiary eligibility rules and changes in beneficiary enrollment.

Furthermore, the state consistently ranks at the bottom across the nation for a number of health indicators, which also contributes to rising Mississippi Medicaid costs. Medicaid takes care of the state's most vulnerable residents, and Mississippi has some of the highest health disparities in the nation.

DOM supports developing a strong connection between expenditures and program performance, such as identifying factors contributing to costs which could be modified without jeopardizing health-care access or quality. By increasing the number of beneficiaries enrolled in coordinated care and including inpatient hospital services as part of the program, DOM has realized cost avoidance and cost predictability for a large percentage of the population we serve. Performance measurement driven operations ultimately result in enhanced quality of care through the use of evidence-based measure sets that have wide acceptability in the health-care industry.

### **External/Internal Assessment**

Medicaid is a federal and state partnership, and the most significant mandates and regulations come from the federal level. These factors include, but are not limited to: CMS, PPACA, HIPAA, OIG and the OCR. Potential changes regarding how we will be funded at the federal level could impact our services, provider reimbursement rates, eligibility and ultimately, enrollment.

DOM is also one of the most highly codified and statute-regulated Medicaid programs in the nation. Programmatic changes often require changes to state law, leaving us little flexibility to adapt to developing trends. Factors that impact us on the state level include but are not limited to: The Mississippi Medicaid State Plan, State Plan Amendments, and regulations from other state agencies.

Despite these challenges, over the last two years the agency's financial team has calculated our budget projections within 0.2 and 0.3 percent difference, which highlights our efforts to establish budget predictability measures. We turn our nearly \$1 billion budget into almost \$6 billion, most of which goes to providers, operating with one of the lowest Medicaid agency administrative costs in the country.

Although Mississippi did not expand Medicaid eligibility under the PPACA, the law has mandatory requirements that continue to impact DOM in the following ways:

- Extend health coverage for foster children from age 21 to age 26.
- Implement Modified Adjusted Gross Income (MAGI) rules when determining eligibility for Medicaid benefits. Adoption of these federally mandated standards has the collective effect of increasing income limits for Medicaid eligibility by nine percent.
- Modernize the system for eligibility determination to accommodate new MAGI rules.
- Transitioned over 20,000 children from CHIP to Medicaid.
- Reimburse primary care providers at enhanced rates equal to those paid by Medicare. (Increased funds for the payments from the federal government have since ended, and the Legislature authorized continuing the enhanced payments with state funds.)
- Private health insurers are required to pay an annual fee, which results in higher fees from coordinated care.
- Increased enrollment due to the welcome mat population – people who were not enrolled prior to PPACA, but are currently enrolled due to new PPAC eligibility rules.

Many of these mandates have had significant impacts on our programs, and it has taken an extensive amount of time, planning and funding to ensure we have the staff to meet both state and federal mandates.

Building upon the strategic planning process to streamline operations and improve communications, the agency continues to evolve and initiate internal changes to ensure organizational efficiency and to accommodate increasing oversight of operations and compliance of the coordinated care environment. There have been steps made to increase accessibility, transparency and connection with other agencies to open avenues of communication, work more collaboratively and emphasize staff training.

Lastly, in addition to DOM policies and procedures, we have dedicated offices and staff in charge of program integrity, combating fraud and abuse, contract compliance, and third party recovery.

## Agency Program Goals, Objectives and Strategies

### Program 1: Medical Services

**Goal A:** Ensure all Mississippi residents eligible for Medicaid have health coverage

**Objective A.1:** Educate the public about Mississippi Medicaid program

Outcome: Percentage change in number of recipients enrolled from prior year

**Strategy A.1.1:** Continue DOM educational and outreach efforts

Output: Number of Mississippians on Medicaid

**Objective A.2:** Encourage provider enrollment and participation in Medicaid

Outcome: Percentage change in number of providers from prior year

**Strategy A.2.1:** Continue DOM educational and outreach efforts for providers

Output: Number of providers submitting electronic claims

Output: Number of providers enrolled in Medicaid

**Objective A.3:** Inform current Medicaid beneficiaries of services available to them

Outcome: Percentage of Medicaid beneficiaries assigned to a primary care physician

**Strategy A.3.1:** Inform beneficiaries of health services, including preventive and wellness services

Output: Number of Medicaid beneficiaries assigned to a primary care physician

Output: Number of wellness visits and physical exams for adults and children

Output: Number of Medicaid beneficiaries enrolled with a coordinated care organization

Output: Number and costs of emergency room visits

Output: Number of kidney dialysis visits

Efficiency: Percentage of MississippiCAN diabetic members aged 17-75 receiving HBA1c testing

Efficiency: Percentage of MississippiCAN members with persistent asthma that are appropriately prescribed medication



Efficiency: Percent change in the number of Medicaid beneficiaries enrolled with a coordinated care organization  
Efficiency: Rate of EPSDT well child screening

## **Program 2: Administrative Services**

**Goal 1:** Provide access to health services for the growing population of Medicaid beneficiaries

**Objective A.1:** Reduce risk of fraud, waste and abuse by beneficiaries and providers by methods such as maintaining internal control assessment requirements provided by the Department of Finance and Administration, and national trends for identifying risk and innovative audit practices

Outcome: Amount of third party liability costs avoided

**Strategy A.1.1:** Continue the numerous DOM activities to combat fraud and abuse

Output: Number of fraud and abuse cases investigated

Output: Number of third party funds recovered

Efficiency: Percentage of clean claims processed within 30 days of receipt

Efficiency: Percentage of clean claims processed within 90 days of receipt

Outcome: Percentage of Medicaid applications processed within Standard Promptness

**Objective A.2:** Properly staff DOM

Outcome: Turnover rate of Medicaid employees

**Strategy A.2.1:** Provide services to Medicaid beneficiaries in the most efficient manner possible while keeping cost at a minimum

Output: Percentage of total budget used for administrative expenses

Explanatory: DOM has one of the lowest administrative costs for a Medicaid program in the nation. It is difficult to retain a workforce that requires specialized knowledge at current salary levels.

## **Program 3: Children's Health Insurance Program (CHIP)**

**Goal A:** Increase access to care for CHIP-eligible children

**Objective A.1:** Ensure children eligible for CHIP are enrolled

Output: Number of CHIP children enrolled

**Strategy A.1.1:** Provide timely screening and eligibility determinations for CHIP

Outcome: Percentage of CHIP applications and redeterminations that are processed within the mandated standard of promptness

Explanatory: Transitioned approximately 28 percent of CHIP children to Medicaid as mandated by PPACA. Children with family incomes between 100-133 percent of the federal poverty level are now covered by Medicaid rather than CHIP, but the federal match for these children is equal to the CHIP enhanced match rate.

Explanatory: The federal match rate for Mississippi's CHIP children will increase to 100 percent beginning Oct. 1, 2015.

#### **Program 4: Home and Community Based Services (HCBS)**

**Goal A:** Improve the Home and Community Based Services (HCBS) program and process

**Objective A.1:** Improve access to home and community-based services to rebalance institutional long-term care with community long-term care options

Outcome: Change in percentage of persons on waiting list for HCBS waiver program

**Strategy A.1.1:** Inform interested residents of HCBS waiver program

Output: Number of persons served in waiver program

Output: Number of slots filled in waiver program

Output: Total number of authorized slots approved in waiver program