5-Year Strategic Plan for Fiscal Years 2022-2026

Mississippi Division of Medicaid

Legislative Budget Office

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Mission Statement

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

Statement of Purpose

DOM pays for health coverage for eligible, low-income Mississippians. 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 members.

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. In 1969, the Mississippi Legislature established a Medicaid program in Mississippi. All 50 states, five territories, and the District of Columbia currently participate in this voluntary matching program. DOM also administers the Children's Health Insurance Program (CHIP), a separate state and federal program established by Congress for low-income children in families that earn too much money to qualify for Medicaid.

Agency Philosophy

Values and Principles

DOM is committed to investing in a healthier Mississippi through access to quality services with the values of accountability, consistency and respect. The agency is focused on providing excellent customer service, acting with fiscal prudence, and operating with high integrity.

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 health care 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 #2: 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 #3: Communicable disease

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

Relevant Benchmark #4: 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 #1: Social indicators

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

Statewide Goal #3: Government and Citizens

Relevant Benchmark #1: Cost of Government

- Total Medicaid spending per capita

Relevant Benchmark #2: Government Efficiency

- Administrative efficiency: Expenditures on Medicaid administrative activities as a percentage of total operational expenditures

Overview of the Agency 5-Year Strategic Plan

According to the U.S. Census Bureau, there are nearly three million residents in Mississippi, which translates to almost 1 in 4 Mississippians who currently receive health benefits through regular fee-for-service Medicaid or one of the agency's managed care plans. Approximately 740,000 Mississippians are enrolled in Medicaid and CHIP. Of those, approximately 55 percent are children.

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 provided to Medicaid members. Historically, provider payments and scope of services have been mandated by the Legislature through the Mississippi Medicaid Law. DOM's eligibility requirements have remained relatively unchanged for 16 years and incorporate liberalization policies adopted by the state or the agency since the turn of the century. Nearly all provider payment methodologies are based on volume of service or cost and are not tied to value or quality. These payment mechanisms create a perverse incentive for inefficiency and overutilization. Furthermore, the number of members allowed to enroll in alternative delivery models – including accountable-care organizations, provider-sponsored plans, or managed care organizations – is currently capped by state law.

Historically, reform efforts have been focused on expanding healthcare benefits or provider reimbursement rates. For instance, the Legislature now allows physician-administered drugs to be billed as a medical or pharmacy benefit to allow greater access to care. Reimbursement rates for primary care physicians have been increased, and rates for outpatient hospital services have increased dramatically since 2014. While DOM believes that enhancing services and increasing provider payments have helped ensure access to care, it cannot demonstrate that those changes have improved outcomes or lowered the per capita cost of care. Transforming payment and delivery models may be more impactful than simply offering more services or paying providers more for the same services. Over the next five years, DOM will be exploring additional value-based payments that incentivize quality and cost-efficiency.

This approach will require a commitment in human and technological resources. The use of predictive modeling and innovative data analytics and data sharing will be a hallmark of our approach. DOM also is replacing its antiquated Medicaid Management Information System (MMIS). The MMIS replacement project (MRP Project) is among the most complex and critical technology projects within state government. Additionally, DOM will implement an asset verification system as mandated by the Medicaid and Human Services Transparency and Fraud Prevention Act, gain certification for an Electronic Visit Verification system as mandated by the federal 21st Century Cures Act, upgrade its Clinical Data Infrastructure platform (CDI), and modernize its eligibility system. These initiatives should support better insights and enhance program performance.

DOM will also be building organizational capacity without inflating administrative costs. Job classes and compensation structure for many positions within the agency do not always square with the demands of a sophisticated $6 billion operation that directly impacts a quarter of the state's citizens. Since its inception, DOM has relied on outsourcing for a variety of duties, and contractors will continue to play a pivotal role in

agency operations. For the Medicaid agency to be effective in this modern environment, it must be able to recruit and retain a high-caliber workforce.

Over the next five years, DOM will continue to focus on making data-driven decisions that improve health outcomes of the population, lower costs, improve the client experience and enhance program transparency for the public. However, with an aging population and health care costs continuing to rise, the approaches to achieving these goals may change. The goals, objectives, strategies and performance measures outlined below give further insight into the Medicaid program's trajectory, but this is a living document that is subject to change.

External/Internal Assessment & Internal Management Systems

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, the Patient Protection and Affordable Care Act, the Health Insurance Portability and Accountability Act, the U.S. Department of Health and Human Services, Office of Inspector General (OIG) and Office for Civil Rights (OCR). Potential changes regarding how we will be funded at the federal level could impact our services, provider reimbursement rates, eligibility and ultimately, enrollment.

In addition to federal requirements affecting the program, DOM follows the mandates set forth in the Mississippi Medicaid Law, other statutes, and the annual appropriation bill. DOM considers risks both external and internal that could have an adverse effect on the agency's ability to initiate, authorize, record, process and report financial data consistent with the assertions of management in the financial statements. The risk assessment process is mainly concerned with management's identification, analysis, and response to the risk of material misstatement in the financial statements. There has to be a focus on the objectives of the entity and all related risks associated with trying to achieve those objectives.

External influences include economic conditions, social conditions, external regulation, natural events and political conditions including budgeting of funds and technology changes. Internal influences that contribute to risks include changes in personnel duties and staffing availability, information systems, data processing, cash management activities and asset protection and preservation.

Additionally, the majority of Medicaid cost drivers and expenditures are contingent upon external influences, including rising costs of medical services and pharmaceuticals, state and federal laws and regulations, utilization of services, provider coding patterns, beneficiary eligibility requirements and beneficiary enrollment.

The impact of the global pandemic caused by COVID-19 late in Fiscal Year 2020 on both external and internal influences will likely be felt throughout the five years included in this strategic plan. COVID-19 has affected the economy, regulations concerning Medicaid eligibility and funding as well as workforce availability and planning. More changes that will impact this plan could be forthcoming as the pandemic continues into Fiscal Year 2021.

DOM supports developing a strong connection between expenditures and program performance, such as identifying factors contributing to costs which could be modified without jeopardizing care quality.

Operations driven by performance measurements ultimately result in enhanced quality of care through use of evidence-based measure sets that have wide acceptability in the health care industry. At the same time, reducing contractual spending, reining in non-critical administrative expenses, and taking advantage

prescription drug rebates are some of the measures taken to help the agency operate within its appropriation.

DOM's Office of Eligibility is responsible for Medicaid and CHIP eligibility policy, coordination of policy, procedures and staff training. This office also oversees the administration of 30 regional offices throughout the state and constitutes approximately two-thirds of the agency's workforce. Regional offices are responsible for the determination of eligibility for the aged, blind and disabled groups, as well as families and children. In addition, the Office of Provider Enrollment falls under Eligibility and is responsible for enrolling providers into the Medicaid program.

DOM addresses fraud risk through the Office of Program Integrity. Program Integrity investigates cases of provider fraud or abuse by analyzing provider records, medical charts, eligibility records and payment histories. Also, Program Integrity, in certain cases, conducts interviews with provider staff and medical beneficiaries to help make determinations of potential fraud. The Office of Medicaid Eligibility Quality Control (MEQC) within Program Integrity determines the accuracy of eligibility decisions and investigates complaints alleging improper receipt of medical benefits. DOM employees are specifically prohibited from processing initial applications, redeterminations, or changes for Medicaid benefits of their own, their immediate family members or members of their household. The Data Analysis Unit within Program Integrity creates algorithms that uncover potential areas of fraud and abuse in the Medicaid program. Staff develop analysis reports for use in investigations, collect data for analysis reports and document recovery and recoupment of funds in cases worked by the Office of Program Integrity. The External Audit Contract Management Unit within Program Integrity oversees the activities of external auditors including the Recovery Audit Contractor and the Medicaid Integrity Audit Contractor and their efforts in identification of potential fraud. This unit also reviews various reporting requirements of Managed Care Organizations related to fraud, waste and abuse.

In conjunction with risk assessment, an Agency-Level Internal Control Assessment document is completed under the direction of the State of Mississippi's Department of Finance and Administration (DFA) and is updated annually to ensure controls are documented and in place. The assessment includes documentation and responses from DOM staff to pre-established questions pertaining to certain control activities applicable to the fiscal processes of the agency. This documentation includes control activity assessments for the following areas: Control Environment, Risk Assessment, Control Activities, Information and Communication, Monitoring, Procurement and Accounts Payable, Cash Disbursements, Accounts Receivable, Travel, Grants Administration, Fixed Assets, SPAHRS, MAGIC Security and Fraud, Waste and Abuse.

DOM maintains an Internal Control Plan for the Mississippi Division of Medicaid, which is updated periodically but no less than annually to document the agency's commitment to maintaining strong and effective internal controls. The control environment consists of the actions, policies, and procedures that reflect the overall attitudes of top management and directors about control and its importance to the agency.

To fulfill its statutorily required responsibilities, DOM contracts with an external service organization or fiscal agent to process various aspects of the payment of Medicaid claims. These processes are part of a separate control environment and have separate control functions involved with the daily processing of Medicaid claims.

Finally, DOM has a network risk assessment performed by an external vendor every three years. The most recent external security assessment was performed during June 2019. This vulnerability

assessment was designed to help DOM perform due diligence in maintaining a reasonably secure internal network environment. Network security procedures are performed according to the Network Systems Manual, the Mississippi Department of Information Technology Services (ITS) Enterprise Security Policy and IRS Publication 1075.

The Executive Director is responsible for the overall administration of DOM, which includes working with staff at CMS to maintain compliance with federal laws and regulations, monitoring state legislative activity regarding Medicaid, presenting budget information to the Governor and to the Legislature and working with other agencies and organizations. Also, the Executive Director is ultimately responsible for the implementation of the appropriate levels of internal control for operation of the agency. The Executive Director is appointed by the Governor of the State and serves at the will and pleasure of the Governor. However, the responsibility for carrying out the functions of implementing and maintaining internal control extends to the individuals designated within the agency as part of senior leadership and who report directly to the Executive Director. These individuals within this core group of senior leadership assist the Executive Director to ensure proper direction is both communicated and provided to the staff. The Executive Director's senior leadership team currently includes the Deputy Executive Director, the Chief Integrity Officer, Deputy Administrators for Finance and Eligibility; the heads of the Information Technology Management (iTECH), Human Resources, External Affairs, and Legal groups; the Director of Communications, the Special Assistant to the Executive Director and the Medical Director.

Agency Program Goals, Objectives, Strategies and Measures by Program

Program 1: Administrative Services

Goal 1: Improve quality of services while reducing total cost

Objective 1: Provide services to Medicaid beneficiaries and other customers in the most efficient manner possible while operating within appropriation

Outcome: *Administrative cost as a percent of Total Budget*

Explanatory*: DOM has one of the lowest administrative costs for a Medicaid program in the nation. Under the current compensation and personnel model, retaining and attracting a workforce that requires specialized expertise is difficult.*

Objective 2: Ensure that DOM does not consume unfair share of limited state resources that could be used by Legislature on other core functions of government

Outcome: *Percentage of state support spending for Medicaid remains level or is reduced*

Outcome: *Share of annual state support spending compared to other agencies*

Strategy 1: *Keep Medicaid's percentage increase in state support spending at or below total percentage increase of all agencies*

Output: *Number of Medicaid employees*

Output: *Number of regional offices*

Strategy 2: *Ensure managed care rates are actuarially sound while maintaining fiscal discipline*

Efficiency: *Percentage increase in annual managed care capitation rates (excluding supplemental payments)*

Strategy 3: *Build organizational capacity by retaining, developing, and attracting a high-quality, high-value Medicaid workforce*

Outcome: *Employee turnover rate*

Strategy 4: *Ensure optimal matching rates for necessary administrative services*

Efficiency*: Percentage of state share spending as a percentage of total administrative expenditures*

Efficiency: *Percentage of Medicaid appropriated state support funds used to support 100% state-funded projects*

Strategy 5: *Improve data analytics to improve decision-making capacity, inform public of program performance, and promote continuous improvement*

Output: *Providers Submitting Electronic Claims*

Output: *Publication of public-facing dashboard (1-accomplished)*

Output: *Number of connections with providers and managed care organizations to clinical data infrastructure platform*

Output: *Number of Consolidated-Clinical Document Architecture (C-CDAs) exchanged*

Output: *Number of beneficiaries with clinical records in Central Data Repository (CDR)*

Output: *Number of providers utilizing provider portal*

Efficiency*: Percentage of Program Integrity recoveries discovered by data mining*

Outcome*: Applications Processed within Std. of Promptness (%) – Medicaid*

Strategy 6: *Reduce unnecessary provider burdens that do not advance quality of program integrity*

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

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

Strategy 7: *Discourage low-value provider practices and swiftly address abuse, fraud, and improper payments*

Output: *Third Party funds Recovered*

Outcome*: Third Party Liability Cost Avoided ($Thou)*

Program 2: Medical Services

Goal 1: Improve quality of services while reducing total cost

Objective 1: Implement payment incentives or disincentives to providers based on quality and value

Outcome: *Percentage of value-based contracts with providers in managed care*

Outcome: *Percentage of quality-based payments in hospital supplemental payment program*

Outcome: *Percentage of nursing homes in high-quality (4 or higher) facilities*

Outcome: *Percentage of capitation tied to withhold or incentive arrangement*

Strategy 1: *Transform the hospital supplemental payment program from a predominately pass-through payment model to one that recognizes value or outcomes over volume of services*

Output: *Amount of hospital supplemental payments in managed care*

Strategy 2: *Within five years, deploy a value-based payment methodology for nursing facilities*

Output: *Number of Mississippi nursing homes reviewed in CMS 5-Star Nursing Home Rating system*

Output: *Amount of dollars tied to value-based payments*

Efficiency: *Percentage of expenditures on value-based payments to nursing homes compared to total nursing home spending*

Strategy 3: *Include withhold or incentive arrangements in capitation rates of Medicaid managed care organizations*

Output: *Number of managed care organizations participating in incentive withhold program*

Efficiency: *Percentage of managed care organizations meeting the criteria to receive incentive or avoid withhold*

Objective 2: Promote effective coordination of care, and effective prevention and treatment of chronic diseases

Outcome*: Percentage of women delivering a live birth who had a postpartum visit on or between 21 and 56 days after delivery*

Outcome: *Percentage of adults who had a diagnosis of hypertension and whose blood pressure was adequately controlled*

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: *Rate of EPSDT well child screening*

Strategy 1: *Shift emphasis from reacting to episodic treatment of illness to one empowering members to be proactively engaged in prevention, wellness and avoidance of chronic disease*

Output: *Medicaid Recipients – Enrolled (Persons)*

Output: *Costs of emergency room visits*

Output: *Number of emergency room visits*

Output: *Child Physical Exams (ages 0-20)*

Output: *Adult Physical Exams (21-Older)*

Output: *Rate of wellness visits and physical exams for adults and children*

Output: *Rate of follow-up visits after hospitalization for mental illness: 21 or older*

Output: *Percentage of usage of multiple concurrent anti-psychotics in children and adolescents*

Output: *Percentage well-child visits in the first 15 months of life*

Output: *Rate of immunizations for adolescents (%)*

Output: *Number of beneficiaries utilizing needed services*

Output: *Number of inpatient hospital admissions for diabetes short-term complications per 100,000 enrollee months for adults*

Outcome: *Percentage change in number of recipients enrolled from last year*

Efficiency: *Percentage of children receiving at least one well-child visit in the third, fourth, fifth, and sixth years of life*

Strategy 2: *Utilize contractual mechanisms to elevate managed care performance and explore additional delivery system reform initiatives*

Output: *Number of beneficiaries assigned to a managed care company*

Output: *Number of MCO full-time equivalent employees located in Mississippi*

Output: *Number of beneficiaries receiving care management*

Efficiency: *Percentage of timely submitted encounter data*

Efficiency: *Per member per month medical spending*

Efficiency: *Amount of administrative costs of managed care organizations*

Efficiency: *Percentage of MCO expenditures spent on MCO administration*

Strategy 3: *Partner with CMS on innovative ways to address dual eligibles*

Output: *Number of dual eligibles enrolled in Medicaid*

Output: *Total amount spent on Part A premiums*

Output: *Total amount spent on Part B premiums*

Objective 3. Maintain and enhance a robust network of high-quality providers
Strategy 1: *Reduce unnecessary provider burdens that do not advance quality of program integrity*

Outcome: Percentage change in Medicaid providers from prior year

Strategy 2: *Discourage low-value provider practices and swiftly address abuse, fraud, and improper payments*

Output: *Number of fraud and abuse cases investigated*

Output: *Amount of money recovered (fraud, abuse and improper payments)*

Strategy 3: *Ensure reasonable fees, charges, and rates for medical services "at the minimum level absolutely necessary to provide the medical assistance authorized by [The Mississippi Medicaid Law]."*
Output: *Number of Medicaid providers*

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

Goal 1: Improve quality of services while reducing total cost

Objective 1: Implement payment incentives or disincentives to providers based on quality and value

Outcome: *Percentage of value-based contracts with CHIP providers*

Strategy: *Encourage managed care organizations to enter into value-based contracts with providers*

Output: *Number of CHIP providers*

Objective 2: Promote effective coordination of care, and effective prevention and treatment of chronic diseases

Outcome: *Percentage of applications processed within the standard of promptness*

Strategy: *Shift emphasis from reacting to episodic treatment of illness to one empowering members to be proactively engaged in prevention, wellness and avoidance of chronic disease*

Output: *Number of CHIP enrollees*

Output: *Number of beneficiaries utilizing needed services*

Program 4: Home and Community Based Services (HCBS)

Goal 1: Improve the health and care for beneficiaries enrolled in Home and Community Based Services (HCBS) program

Objective A.1: Increase the percentage of beneficiaries with a nursing home level of care who receive Long Term Services and Supports in a home or community-based setting instead of an institutional setting

Output: *Elderly & Disabled - Persons Served*

Output: *Elderly & Disabled - Funded Slots*

Output: *Elderly & Disabled - Total Authorized Slots*

Output: *Assisted Living - Persons Served*

Output: *Assisted Living - Funded Slots*

Output: *Assisted Living - Total Authorized Slots*

Output: *Independent Living - Persons Served*

Output: *Independent Living - Funded Slots*

Output: *Independent Living - Total Authorized Slots*

Output: *Traumatic Brain Injury - Persons Served*

Output: *Traumatic Brain Injury - Funded Slots*

Output: *Traumatic Brain Injury - Total Authorized Slots*

Output: *Intellectual Disability - Persons Served*

Output: *Intellectual Disability - Funded Slots*

Output: *Intellectual Disability - Total Authorized Slots*

Outcome: *Percentage of long-term services and supports beneficiaries in home or community-based waiver programs*

Strategy A.1.2: *Promote transition services to help transition appropriate waiver participants from an institutional setting to a home or community-based setting*

Output: *Number of persons transitioned from nursing home to HCBS through a Medicaid program*

Efficiency: *Expenditures on home & community-based services as a percent of total long-term services and supports*

Output: *(E&D) change in persons on waiting list %*

Output: *(AL) change in persons on waiting list %*

Output: *(IL) change in persons on waiting list %*

Output: *(TBI) change in persons on waiting list %*

Output: *(IDD) change in persons on waiting list %*