5-Year Strategic Plan for Fiscal Years 2020-2024

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 900 employees located throughout one central office, 30 regional offices and over 80 outstations. The agency's 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 its mission by conducting agency operations with the values of accountability, consistency and respect.

The agency strikes a fine balance of complying with state and federal requirements, collaborating with a variety of stakeholders and partners in state government 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 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 #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 two 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 2017, which translates to almost 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, 2018, 729,729 Mississippians were enrolled in Medicaid and CHIP. The largest population we serve is children, who comprise approximately 56 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 the 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 while being fiscally responsible and containing costs. Provide better care for beneficiaries through coordinated care and innovative technology, such as telehealth and interoperability connections. 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.
- 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 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. At the same time, reducing contractual spending, unnecessary administrative expenses and taking advantage prescription drug rebates are some of the measures taken to help the agency live within its appropriation.

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, 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.

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 receive needed quality services in order to produce better health outcomes.

Objective A.1: Educate current beneficiaries about the services available to them, how to access them and to encourage compliance with their health care.

Outcome: Percentage change in number of current beneficiaries utilizing needed services

Strategy A.1.1: Continue DOM educational and outreach efforts

Output: Number of beneficiary workshops held and attendance rate
Output: Number of health fairs Medicaid staff members attend
Output: Number of beneficiary resources available on Medicaid website and the frequency of unique and returning visitors to those resources
Efficiency: Average time spent training or updating the website
Explanatory: More classes or trainings are being offered

Strategy A.1.2: 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
Explanatory: More beneficiaries are being informed of services and preventive care, leading to better health outcomes

Objective A.2: Educate health-care providers about enrollment and participation in Medicaid to ensure a robust network and accessibility.

Outcome: Percentage change in number of providers from prior year. Percentage change in number of providers who do not fail to revalidate versus 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
Output: Number of provider workshops held and attendance rate
Output: Number of provider news notices released to our medical associations ListServ and the number of news notices republished by those associations
Output: Number of provider news notices published on the Medicaid website and the frequency of unique visitors to those news notices
Output: Number of downloads of the quarterly Provider Bulletin newsletter from the Medicaid website
Efficiency: Average time spent training or updating the website
Explanatory: More classes or trainings are being offered

Program 2: Administrative Services

Goal 1: Practice fiscal responsibility and strive to be a good steward of state and federal resources.

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
Efficiency: Percentage of Medicaid applications processed within Standard Promptness
Explanatory: Amount of money recovered

Objective A.2: Properly train DOM staff.

Outcome: Turnover rate of Medicaid employees

Strategy A.2.1: Provide services to Medicaid beneficiaries in the most efficient manner possible while controlling costs

Output: Number of Medicaid employees and the number of ROs
Efficiency: 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: To administer a successful CHIP program that produces good health outcomes.

Objective A.1: Educate current CHIP beneficiaries and/or their caretakers about the services available to them, how to access them and to encourage compliance with their health care.

Outcome: Percentage change in number of current CHIP beneficiaries utilizing needed services

Strategy A.1.1: Continue CHIP educational and outreach efforts

Output: Number of beneficiary workshops held and attendance rate
Output: Number of health fairs Medicaid staff members attend
Output: Number of beneficiary resources available on Medicaid website and the frequency of unique and returning visitors to those resources
Efficiency: Average time spent training or updating the website
Explanatory: More classes or trainings are being offered

Strategy A.1.2: Inform CHIP 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 CHIP diabetic members aged 17-75 receiving HBA1c testing
Efficiency: Percentage of CHIP members with persistent asthma that are appropriately prescribed medication
Explanatory: Number of enrolled CHIP beneficiaries compared to prior year

Program 4: Home and Community Based Services (HCBS)

Goal A: Ensure a successful Home and Community Based Services (HCBS) program that promotes greater Long Term Services and Supports delivered in a home or community based setting.

Objective A.1: Increase the number of beneficiaries receiving Long Term Services and Supports in a home or community based setting versus an institutional setting.

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
Efficiency: Number of slots filled in waiver program
Output: Total number of authorized slots approved in waiver program
Explanatory: How many slots were filled compared to the prior year

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 through the Bridge to Independence Program
Output: Number of persons transitioned through the Community Transition Service
Output: Number of active referrals in the Community Transition Service
Efficiency: Average cost savings
Explanatory: Number of waiver participants transitioned