



5-Year Strategic Plan for Fiscal Years 2024-2028

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 850,000 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, primarily in Mississippi Code Section 43-13-117. DOM's eligibility requirements have remained relatively unchanged for 18 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. 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 of human and technological resources. The use of predictive modeling, innovative data analytics, and data sharing accomplished through the use of a data lake 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.

Procurements for Non-Emergency Transportation (NET) and Managed Care during FY2022-2023 and a contract amendment with DOM's Fiscal Agent for Pharmacy Benefit Administration will provide opportunities for DOM to leverage new contract requirements with new and/or existing vendors to improve health outcomes and quality of life for members, which will in turn make for improved cost outcomes for the state. With 10 years of groundwork in managed care, DOM has had the opportunity to build an infrastructure to deliver services, review data, conduct analyses of the coordinated care organization (CCO) framework, and chart a course for DOM and contracted CCOs to deliver the best

possible services to Mississippi's Medicaid population. With the new CCO contract, DOM will also have joint administrative CCO services for both MississippiCAN and the Children's Health Insurance Program (CHIP). The new CCO contract will have requirements for care management, value-based payment arrangements and allow for the use of Patient Centered Medical Homes, all with the goal of delivering better care to Mississippi Medicaid beneficiaries. Enhanced vendor performance measurements will be required in the new NET contract which DOM hopes to lead to higher member satisfaction. A centralized Pharmacy Benefit Administrator will allow pharmacy providers to submit claims to DOM's single Medicaid claims payor while availability of pharmacy benefit utilization data will be prioritized to provide CCOs the information needed to continue to effectively manage the care of their members.

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. To keep pace with its workforce, DOM is planning for the procurement and implementation of an enterprise-wide workflow solution which will streamline administrative effort for both employees and management.

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.

Over the next three years, DOM will focus on the area of Home and Community Based Services (HCBS). The American Rescue Plan Act included enhanced federal funding for HCBS, and the additional funding to DOM is estimated to be \$74.8 million. The additional funds must be spent by March 31, 2025. DOM is collaborating with our sister agencies and external partners to take advantage of this enhanced funding to implement projects supporting three key initiatives:

- Expand access to HCBS by increasing capacity across our 1915(c) waivers and reducing waiting lists;
- Innovations grants to authorize direct spending on community proposed short-term or one-time initiatives to enhance HCBS; and
- Strengthen HCBS technology and infrastructure to enable more effective care coordination access and delivery.

Strategic planning sessions conducted in 2021 with the Senior Leadership members at DOM identified four key areas of focus: technology solutions and infrastructure; workforce training, development and recruitment; vendor selection and oversight; and data analysis for improved outcomes. Senior Leadership is pursuing each of these strategies and continues to gather data about agency needs at all levels for these initiatives.

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 beginning in late Fiscal Year 2020 and continuing through the end of Fiscal Year 2022 on both external and internal factors 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. Medical costs continue to rise due to staff shortages, higher wages and supply chain issues. Additionally, inflation has risen drastically over the last two years and is likely to have further impact on the costs of medical services..

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 Solutions is responsible for enrolling providers into the Medicaid program. Provider Solutions is working under new leadership to streamline work activities, ensure timely provider enrollments and implement a centralized provider credentialing process.

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. DOM is moving forward with integrating data analytics and the use of Geographical Information Systems as a backdrop to identifying potential provider and beneficiary fraud. This has been highly successful in other states and has reduced the amount of fraud occurring. 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 the 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. DOM has hired a dedicated, full time internal audit resource who has created an annual audit plan and is actively reviewing internal operations, issuing findings and following up on corrective action plans. 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. DOM has been actively working with a new fiscal agent contractor on design and development of the replacement of the Medicaid Management Information System (MMIS). This system change is a massive undertaking and will overhaul DOM's fiscal agent operations. The project is a multi-year effort costing more than \$90 million to implement and will impact the entire network of providers who deliver medical services to more than 850,000 Medicaid and CHIP beneficiaries. The go-live date for the new MMIS is October 3, 2022. DOM expects to see operational efficiencies as a result of this system implementation once processes and procedures have become stable and expects to continue to see improvements in operations during the years of this Strategic Plan.

Finally, DOM has a cyber-security risk assessment performed by an external vendor every three years. The most recent external security assessment was performed during June 2021. This assessment was

designed to help DOM perform due diligence in maintaining a secure computing environment as technology configurations evolve. DOM's internal security procedures are performed according to the Mississippi Division of Medicaid Information Security and Risk Management Policy, 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. Additionally, 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. 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 Deputy Administrators for Finance, Eligibility, Health Policy and Services, Accountability and Compliance, Business Operations and Solutions, Legal; the leaders of Information Technology Management (iTECH), Human Resources, Legislative Services, Managed Care Operations, Communications, and the Assistant to the Executive 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. 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

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

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

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

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

Output: Providers Submitting Electronic Claims

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

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

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

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

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

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)

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

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

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*

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

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

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

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: (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 %