MISSISSIPPI DIVISION OF
MEDICAID

5-Year Strategic Plan for Fiscal Years 2026-2030

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Mississippi Department of Finance and Administration

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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, 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. DOM also administers the Children's Health Insurance Program (CHIP), a separate 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. Today, seven values drive our path forward.

Agility: Promptly adapt to new directives and expectations. Create and refine systems and processes that are capable of meeting ever-evolving demands in an environment where the only constant is change.

Collaboration: Work openly and effectively with colleagues, sister state agencies, other branches of state government, the federal government, clinicians, beneficiaries, and caregivers in a highly interdependent environment.

Customer Focus: Pursue an excellent customer experience by being mindful of the customer journey and by understanding the perspective of customers served.

Excellence in Execution: The heart, or foundation, of any successful executive department agency is effective execution. Success requires more than good intentions. Medicaid must effectively implement directives from a variety of state and federal stakeholders and align policies from multiple sources with a variety of complex systems. The agency's work must be performed consistently, correctly, and timely.

Fiscal Prudence: Public servants must be good stewards of taxpayer funds. This concept is deeper than merely minimizing spending and involves adopting approaches most likely to deliver the best value to the taxpayer.

Integrity: Do the right things, the right way. The concept of high integrity encompasses several qualities, including accountability, compliance, honesty, and fairness.

Respect: An enduring value. Respect for one another and a variety of viewpoints is a necessary element of a healthy organizational culture.

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

In June 2024, over 700,000 Mississippians received health coverage through Medicaid and the Children's Health Insurance programs. The pandemic and its aftermath spurred dramatic change, but Mississippi Division of Medicaid's (DOM's) core focus remains the same: to deliver better value and higher quality to the people it serves at a sustainable cost in compliance with state and federal mandates.

Much of the direction of the Mississippi Medicaid program is set outside of the state Medicaid agency. The federal government and the Mississippi Legislature each play significant roles in this joint state-federal Medicaid program. Congress sets out the mandatory and optional populations through the Social Security Act. The Mississippi Legislature, not the state executive branch, decides the groups of individuals who are eligible for Mississippi Medicaid. Beneficiary eligibility primarily 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 federal government, 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 providing federal funding – known as a federal financial participation, or FFP – for a portion of Medicaid services. The match rate for medical expenditures is called the Federal Medical Assistance Percentage (FMAP). Variations in the FMAP have a significant impact on funding the non-federal share of Medicaid services. Through a contract between the state and the federal government known as the Medicaid state plan, CMS approves the services and activities for which these federal matching funds are available.

The scope of covered benefits, and many provider payment methods, are mandated by the Mississippi Legislature through the Mississippi Medicaid Law, primarily Mississippi Code Section 43-13-117. The number of members allowed to enroll in alternative delivery models – including accountable-care organizations, provider-sponsored plans, or managed care organizations – is capped by statutes.

Procurement policies are largely dictated by the state legislature, federal agencies, the Mississippi Department of Information Technology Services (ITS), and the Public Procurement Review Board.

The vast array of checks and balances that have been placed on the Mississippi Medicaid program help minimize risk. They also make any agency 5-year strategic plan quite speculative.

If the Medicaid program is a large puzzle, the state Medicaid agency helps ensure the pieces fit together as best as possible, and occasionally adds a missing piece when authorized to do so. Amid this web of federal and state requirements, evolving expectations, and continuous disruption, DOM is working to

shape and reshape various elements of the agency rapidly and inexpensively in an ongoing effort to deliver high-quality services and a good customer experience to the public.

The Legislature has historically divided the Division of Medicaid budget into four programs – Administrative Services, Medical Services, CHIP, and HCBS. DOM's annual Strategic Plan to LBO is organized around these four programs.

- In the administrative services program, achieving operational excellence at a reasonable cost remains a major pursuit. Experience has shown that DOM will have to become more sophisticated to deliver the simplicity that clinicians and members want from a Medicaid program while satisfying increasingly complex external requirements.
- The medical services program consumes most Medicaid expenditures. Exploration and adoption of additional value-based payment models that incentivize high-quality care is one critical tool to preserve health access and to advance health care delivery. But adopting new payment methods must be well-considered. Ensuring traditional state plan approved rates meet state and federal statutory requirements and attract a strong pool of clinicians remains a focus.
- The separate CHIP program is likely to become more aligned with the traditional Medicaid program while preserving some of its unique features.
- The Home and Community Based Services (HCBS) program will continue to grow sustainably. The American Rescue Plan Act included enhanced federal funding for HCBS, and the additional funding to DOM is $63 million. The additional funds must be spent by March 31, 2025. DOM is collaborating with sister agencies and external partners to take advantage of this enhanced funding to implement projects supporting three key initiatives to (1) expand access to HCBS by increasing capacity across our 1915(c) waivers, (2) support the HCBS workforce through one-time initiatives to study the provider landscape, reevaluate service rates and educate providers, and (3) strengthen HCBS technology and infrastructure to enable more effective care coordination access and delivery.

In past strategic planning sessions, DOM senior leadership identified four key areas of concentration: technology solutions and infrastructure; workforce development and recruitment; vendor selection and oversight; and data analysis for improved performance.

The goals, objectives, strategies, and performance measures outlined below give insight into the Medicaid program's trajectory, but this is a living document that is subject to change.

External/Internal Assessment & Internal Management Systems

External Assessment

Medicaid is a federal and state partnership, with many significant mandates and regulations coming from the federal level. CMS regulations, the Patient Protection and Affordable Care Act (ACA), the Health Insurance Portability and Accountability Act (HIPAA), the Families First Coronavirus Response Act (FFCRA), the Consolidated Appropriations Act of 2023 (the FY23 Omnibus), the U.S. Department of Health and Human Services, Office of Inspector General (OIG) and Office for Civil Rights (OCR), are some of the key drivers at the federal level.

During FY2024, CMS finalized rule changes that will reshape the federal regulatory landscape for Medicaid and CHIP. These proposed rule changes have implementation requirements both before and during the years of this strategic plan. DOM is working on a roadmap that ensures these new requirements will be met in a timely manner.

CMS's approach to health-related social needs could change the trajectory of Medicaid financing. While furnishing medical assistance to certain vulnerable populations has been Medicaid's core objective since the mid-1960s, CMS is offering federal financial participation for certain services beyond traditional medical assistance. It remains unclear if this scope expansion will impact Mississippi or if these new flexibilities will be narrowly tailored to meet some specific federal policy preferences.

Other external factors related to CMS include its new interpretations of certain financing policies and whether those interpretations will impact FFP.

The Legislature continues to provide ongoing direction. Thanks to consistent legislative support and an agencywide commitment to cost containment, DOM has avoided a state support budget deficit since SFY2018 and was able to get back on strong financial footing by early 2020. The 6.2 percentage point FMAP enhancement during the public health emergency has furthered improved DOM's financial condition despite additional costs related to enrollment growth.

By 2026, a substantial increase in general funds and state support special funds will be required to maintain existing services and benefits, while skyrocketing costs of outpatient drugs (particularly high-dollar gene therapies) will be an added financial pressure.

The financial condition of Medicaid providers also can impact Medicaid spending. If revenue from commercial payers and Medicare is insufficient, more pressure is applied to the state – and to the state Medicaid program – to help finance perceived gaps. Rapid consolidation of medical practices can lead to changes in access and billing. Medical costs due to staff shortages, higher wages, and supply chain issues can directly lead to higher provider reimbursement rates or to public pressure for higher reimbursement rates.

Since its inception, DOM has relied on outsourcing certain duties, and contractors continue to play a sizable role in Medicaid operations. Currently, major Medicaid IT claims processing and eligibility and enrollment systems necessitate significant customization, and the pool of outside vendors and modern, composable alternatives is still relatively limited. The federal push for a more "modular" state Medicaid IT environment presents additional challenges as states have to manage more vendors and more procurements to keep systems aligned and projects on schedule.

Some of Mississippi's procurement laws, regulations, and processes represent a risk to DOM for timely complying with federal directives, elevating performance, and transforming service delivery. As of July 2024, DOM is contending with one active procurement protest and the protest of the managed care procurement has just recently concluded. Rather than being utilized to challenge legitimate flaws in a solicitation or the evaluation, procurement protests – and related protective order proceedings – have been exploited as a delay tactic for unsuccessful offerors. While these delays may be a wise short-term business strategy for an unsuccessful offeror and their outside attorneys, protest delays drive up costs for taxpayers and inhibit DOM's ability to leverage new contract requirements aimed at improving service delivery. While the protest phase is one particular challenge, it is just one part of a procurement process that takes far too long. These long acquisition cycle times are particularly problematic for complex professional and personal services contracts with 5-year lifecycles. The transactional costs of ripping and replacing complex systems or services is immense. Action or inaction around the state procurement system could impact DOM's ability to fulfill its mission effectively going forward.

The implementation of SEC2 Classification and Compensation Plan appears to be a net positive for the state workforce, although the standardization of job titles and pay ranges is worth monitoring for some of

the more complex agencies like DOM. Increases in the PERS employer contribution rate strains resources. Caps on personal services spending could still lead to higher overall costs as agencies turn to more costly independent contractors and other personnel outside the state service to satisfy state and federal mandates.

A number of other external factors can influence Medicaid. Some of these include:

- Changes to the Medicare Fee Schedule (certain Mississippi Medicaid provider rates are dependent on Medicare rates).
- Beneficiary enrollment patterns. The size of the Medicaid population has a very significant impact on the overall cost of the program. Increases or decreases in enrollment can change the trajectory of reform efforts.
- Economic conditions, including unemployment and workforce participation.
- Workforce availability and changes in employee preferences, including remote work.
- Health literacy. While most people likely understand basic preventive messages such as the value of good nutrition and physical activity, it is harder for individuals to discern what they can realistically do to achieve better health. Not only are there confusing and contradictory messages in the media, some people, including Medicaid members, often lack information on how small changes in their daily activities can lead to significant health improvements. Federal Medicaid matching funds are unavailable for general statewide health literacy efforts.

Internally, DOM continues to make progress. While DOM is not immune to staff losses due to retirement and turnover, it has a solid team in place who remain committed to the stated values of Medicaid. Many agency leaders and technical experts have reached or are approaching retirement age. Some vacant positions can be filled internally, but external hiring will continue. Private insurance companies, health and hospital systems, IT vendors, and other state agencies are among DOM's competitors for talent.

DOM continues to work to build organizational capacity without inflating administrative costs. While job classes and compensation structure for many positions within the agency do not always square with the demands of a sophisticated $8 billion operation that directly impacts a third of the state's citizens, more aggressive HR recruitment efforts and the greater classification and compensation flexibility has helped recruitment and retention of a high-caliber workforce. Competitive compensation and career paths for the frontline eligibility workers and their managers will be a focus moving forward. DOM also needs to retain successful Central Office performers, while attracting more individuals to DOM with deep experience in health insurance and clinical operations, as well a high-potential individuals with a capacity for data analysis, clinical and operational quality improvement, project and product management, vendor management, IT, change management, financial and actuarial services, and leadership development.

Improving technology solutions and developing more maturity in certain IT domains will be an important facet of agency transformation. The use of predictive modeling, more robust data analytics, and data sharing through an enterprise data lake will be a key approach going forward. Embracing appropriate AI solutions should enhance customer experience, and advocating for a statewide data mesh through modern channels could improve governmentwide service coordination.

In FY2023, DOM replaced its antiquated Medicaid Management Information System (MMIS). The MMIS replacement project (MRP) was among the most complex and critical technology projects within state government, and one of its longest. DOM has also gained certification for an Electronic Visit Verification system as mandated by the federal 21st Century Cures Act, sought to upgrade its Clinical Data Infrastructure platform (CDI), and added a new online upload mechanism for Medicaid applicants and

members. In FY2024, DOM expects to complete the implementation of a self-service eligibility portal for Medicaid beneficiaries to access more services online. In FY2025, DOM implemented an enterprise-wide workflow solution which will streamline administrative effort for both employees and management. Over the long-term, these initiatives should support better insights, enhance program performance, and improve the experience of providers and members.

DOM implemented a new Utilization Management/Quality Improvement Organization contract in early 2024 and a new contract for Non-Emergency Transportation (NET). A contract amendment with DOM's Fiscal Agent for the implementation of a single Pharmacy Benefit Administrator 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 lead to better 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 managed care organization (MCO) framework, and chart a course for DOM and contracted MCOs to deliver the best possible services to Mississippi's Medicaid population. With the new MCO contract cycle which will be operational on July 1, 2025, DOM will also have joint administrative MCO services for both MississippiCAN and CHIP. The new MCO 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 will 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 MCOs the information needed to continue to effectively manage the care of their members.

Internal Management Systems

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 must be a focus on the objectives of the entity and all related risks associated with trying to achieve those objectives.

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 relevant performance measurements are likely to enhance 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 of prescription drug rebates are some of the measures taken to help DOM 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 works with DOM's fiscal agent to enroll providers into the Medicaid and CHIP programs. Provider Solutions is working to streamline work

activities, ensure timely provider enrollments and has implemented a centralized provider credentialling 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 Medicaid Eligibility Quality Control (MEQC) unit 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. The External Audit Contract Management Unit within Program Integrity oversees the activities of external auditors including the Medicaid Integrity Audit Contractor and its 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 worked with a new fiscal agent contractor on design and development of the replacement of the Medicaid Management Information System (MMIS). This system change has been a massive undertaking and overhauled DOM's fiscal agent operations. The project impacts the entire network of providers who deliver medical services to more than 700,000 Medicaid and CHIP beneficiaries. 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 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.

Agency Program Goals, Objectives, Strategies and Measures by Program

Program 1: Administrative Services

Goal 1: Improve quality of services while minimizing 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 or member burdens*

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 minimizing 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 2: *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 %*