



MISSISSIPPI DIVISION OF
MEDICAID

5-Year Strategic Plan for Fiscal Years 2028-2032

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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 in Title XXI of the Social Security Act 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 2026, 695,000 Mississippians received health coverage through Medicaid and the Children's Health Insurance programs. Dramatic change has been spurred in recent years by the COVID-19 pandemic and its aftermath. Additionally, extensive federal reforms through both Congress and regulatory agency rulemaking have triggered some fundamental changes to Medicaid financing and the healthcare ecosystem. However, the Mississippi Division of Medicaid's (DOM) 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. 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 members allowed to enroll in alternative delivery models – including accountable-care organizations, provider-sponsored plans, or managed care organizations – is set in statute.

The vast array of checks and balances that have been placed on the Mississippi Medicaid program help minimize risk. They also make the agency's 5-year strategic plan quite speculative. Recent changes to federal legislation and federal rulemaking increase the uncertainty of any future projections and plans. 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 Division of Medicaid is undertaking a comprehensive enterprise transformation that modernizes how Medicaid services are delivered to beneficiaries, providers, and agency staff. These initiatives include modernizing core eligibility and Medicaid Management Information System capabilities, implementing an enterprise operational data store and interoperability platform, expanding secure digital identity management, strengthening cybersecurity and system observability, and deploying standards-based Application Programming Interfaces (API) that improve data sharing across the healthcare and state government ecosystem. Several of these initiatives are driven by federal requirements, including the CMS Interoperability and Prior Authorization Final Rules (CMS_9115-F, CMS-0057-F, CMS-0062-P, CMS-0053-F), Working Families Tax Cut (WFTC) legislation, 2023 Consolidated Appropriation Act, etc. which requires implementation of Patient Access, Provider Access, Payer-to-Payer, Provider Directory, and Prior Authorization APIs using HL7® FHIR® standards. Additional modernization efforts support compliance with HIPAA transaction standards, CMS Medicaid Enterprise System (MES) guidance,

MARS-E/ARC-AMPE security requirements, and evolving CMS expectations for modular, interoperable, cloud-based Medicaid systems.

Collectively, these transformation efforts will create a more connected, secure, and data-driven Medicaid enterprise that improves the experience of both beneficiaries and providers. Beneficiaries will benefit from faster access to healthcare information, more streamlined enrollment and identity verification processes, improved care coordination, greater transparency into prior authorization decisions, and more timely delivery of services. Providers will experience simplified interactions with the agency through modern digital portals, reduced administrative burden, faster access to eligibility and claims information, improved interoperability with electronic health records, and more efficient prior authorization workflows. At the same time, the agency will gain enhanced analytics, stronger program integrity capabilities, real-time performance monitoring, improved cybersecurity, and the flexibility to adapt more rapidly to future federal requirements and changing healthcare needs, ultimately resulting in a more efficient, responsive, and sustainable Medicaid program for the citizens of Mississippi.

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. Oversight of contractual obligations is an important step in that 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. However, adopting new payment methods increases complexity for staff, providers and systems and 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 becoming more aligned with the traditional Medicaid program while preserving some of its unique features. The newest managed care contracts which went into operation in July 2025 combined CHIP and managed care functions for the first time.
- The Home and Community Based Services (HCBS) program will continue to be an important support for those members who are eligible, but growth in program membership has been paused in recent years due to budget constraints. In fiscal year 2025, an HCBS workforce and rate study were performed. This information was used as a basis for a rate increase at the beginning of calendar year 2026. Although DOM did not receive an appropriation increase to cover the additional cost for fiscal year 2026, the increase was implemented at the legislature's request in January. Both the MS Department of Rehabilitation Services and the MS Department of Mental Health received appropriations to fund HCBS waiver rate increases in FY2026 for the waivers they administer. The services provided under the different waivers are paid through Medicaid and are generally the same services for different populations. In future years, funding for all three agencies should be provided to meet legislative expectations for rate increases as the agencies try to maintain a rate structure that supports access to services for these vulnerable populations.

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. This trajectory and any plans are also decidedly subject to limitations on state funding provided by the Legislature in the annual appropriation process. For FY2027, the appropriation provided \$153 million less in state funding needed to meet the annual spending projection. Because those funds are used to match and draw down federal funds, the actual budgeted shortfall is approximately \$660 million. Funding provided in future years will have an impact on the agency's ability to fully meet the listed goals, objectives, strategies and performance measures. Most importantly, this funding will either impact the state's ability to pay providers the current rates for services performed, or it will impact the services available to members.

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), WFTC legislation, 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.

Furnishing medical assistance to certain vulnerable populations has been Medicaid's core objective since the mid-1960s. Recent federal leadership changes and federal legislation has seen a resurgence in this core objective with less focus on offering federal financial participation for certain services beyond traditional medical assistance.

During fiscal year 2024-2026, CMS finalized rule changes that will reshape the federal regulatory landscape for Medicaid and CHIP. These rule changes and some proposed rules have implementation requirements both before and during the years of this strategic plan. Other external factors related to CMS include directives in the WFTC legislation related to reducing fraud and improving the enrollment processes, preventing wasteful spending, stopping abusive financing practices, expanding access to access to care (HCBS), and rural health transformation. DOM is incorporating the newest regulations into a roadmap that ensures these new requirements will be met in a timely manner.

The Legislature continues to provide ongoing direction to the agency. Thanks to consistent legislative support and an agencywide commitment to cost containment, DOM avoided a state support budget deficit from SFY2018 to SFY2025. Beginning in 2027, 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) and an aging population and increased costs to care for that population will add 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. Federal law changes reducing Medicaid's ability to pay an average commercial rate through managed care directed payments will impact hospital and ambulance provider payments beginning in fiscal year 2029. The change is expected to reduce those payments by about \$150 million annually. There will be an offsetting increase in disproportionate share hospital payments and a decrease in the provider tax paid to support these payments. Overall, there is an expected net decrease in provider payments for each year 2029 through 2034 of about \$100 million.

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. 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 cost 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. The interest in limiting agency autonomy within legislative guardrails through pay adjustment restrictions may lead to higher overall costs and loss of highly performing staff.

Limitations of the state's enterprise resources continue to be a source of frustration for administrative staff. The systems are antiquated, use an aging infrastructure and are a barrier to efficiency and innovation.

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 and CHIP 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.
- Utilization of services by Medicaid and CHIP membership
- 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 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 source 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. Two bills passed by the 2025 Legislature, House Bill 1491 Cloud Center of Excellence and Senate Bill 2267 Mississippi Statewide Data Exchange Act, will have an impact on planning for IT services for the agency during the coming years.

With the new MCO contract cycle which became operational on July 1, 2025, DOM will have joint administrative MCO services for both MississippiCAN and CHIP. The new MCO contract will be operational until June 30, 2030 and has requirements for care management, value-based payment arrangements and allows for the use of Patient Centered Medical Homes, all with the goal of delivering better care to Mississippi Medicaid beneficiaries.

DOM continues to work with the other state agencies delivering services to Medicaid beneficiaries to find efficient delivery methods at the best state and federal cost for those services.

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 31 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. 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 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 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. From 2018 to 2022, 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 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. Continued use of this system is contingent on legislative action. Due to the significant investment of Federal and State funds and time and effort by DOM staff, DOM is requesting legislative change to allow continued use of the fiscal agent contract. This contract is currently limited to 10 years. Implementation of the software took over five years, leaving less than five years in operation.

A new fraud, waste and abuse analytics platform is being implemented during fiscal year 2026-2027, and the agency expects to see results from this new system in the coming years. The agency is also procuring contracts to conduct audits of a larger number of long-term care facilities, conduct an audit of Pharmacy Benefit Administration and pharmacy claims payments, and conduct an audit of medical claims payments made by our Fiscal Agent. The agency is hoping to ensure the highest level of payment integrity through these reviews.

Finally, DOM has a cyber-security risk assessment performed by an external vendor every two years. The most recent external security assessment completed was performed during July 2024 with the next cycle's assessment underway and scheduled for completion in August 2026. 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 Acceptable Risk Controls for ACA, Medicaid, and Partner Entities (ARC-AMPE) which is a modernized cybersecurity and privacy framework published by the Centers for Medicare & Medicaid Services (CMS).

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 %