

**DIVISION OF MEDICAID
OFFICE OF THE GOVERNOR
FIVE YEAR STRATEGIC PLAN**

1. **Mission Statement**

The mission of the Mississippi Division of Medicaid is to ensure access to health services for the Medicaid eligible population in the most cost efficient and comprehensive manner possible and to continually pursue strategies for optimizing the accessibility and quality of health care.

2. **Overview of the Agency 5-Year Strategic Plan:**

The Division of Medicaid promotes flexible state legislation from the Mississippi Legislature to allow the Agency discretion to run the Agency in accordance with federal regulations.

The Division of Medicaid seeks to offer high quality, cost-effective health care services to all qualified beneficiaries. The Division of Medicaid continues to develop innovative and cost efficient programs to allow for the provision of maximum health benefits to qualified eligibles. The agency seeks to improve the status of healthcare across the state and create a platform to cease reacting to illness and empower beneficiaries to be proactive and focus on prevention, wellness, and avoidance of chronic disease.

The Division of Medicaid promotes the development and distribution of quality measures and information as a basis for supporting effective quality improvement efforts and long term strategic planning by understanding and quantifying the costs of Division of Medicaid services and weighing these costs when deliberating budgeting tradeoffs. The Division of Medicaid supports developing a strong connection between costs of the agency and program performance, i.e., identify factors contributing to costs which could be modified without jeopardizing access or quality. Performance measurement driven operations ultimately result in enhanced quality of care through the use of evidence-based measure sets that have wide acceptability in the healthcare industry. The Division of Medicaid will continue to use the following resources and methods for information dissemination to assist in performance measurement promotion:

- Utilize partnership with CMS to benefit from their research findings in best practices to improve performance measurement and thereby, reduce duplication of research efforts.
- Evaluate current improvement efforts to direct future activities.
- Continuing Education of Certified Public Accountants on staff in performance measure areas via the Association of Government Accountants (AGA), Governmental Accounting Standards Board (GASB), Mississippi Society of Certified Public Accountants (MSCPA), American Institute of Certified Public Accountants (AICPA) and others.
- Coordinate with other Federal and State government entities, accreditation bodies, insurers, and professional societies to achieve consensus on common evidence-based measure sets.

- Participate in sharing of information through innovative approaches to emerging issues; using issue briefs, analysis of demonstration evaluations, conferences, Web casts and other methods.

The Division of Medicaid has established goals and strategies to position the agency as a leading provider of health care services as follows:

- Improve the effectiveness and efficiency of the delivery of medical services.
- Maximize available program benefits by containing costs, eliminating duplication, and using all sources of funds.
- Attract and maintain a strong network of service providers by continuously evaluating and implementing programs that strengthen the reimbursement process.
- Continue to enhance and introduce up-to-date management information and communication systems/equipment.
- Provide continuous improvement/utilization review by evaluating service outcomes, program costs, and provider participation to effectively manage resources.
- Participate in Health Information Technology (HIT) Initiatives which benefit the provider, beneficiary and payer. Electronic Health Records (EHR) are expected to result in reduced duplication of medical testing and medical services, as well as enhanced quality of care from the secure sharing of information between providers. Enhancements will be added to increase the efficiency of the overall product. Electronic prescribing (E-prescribing) is an added benefit of the EHR software. E-Prescribing allows the prescriber to access, via a computer or hand-held device, a patient's drug benefit coverage and medication history with a patient's consent, which supports the management process of prescribing, transmitting, dispensing, administering and monitoring. E-Prescribing is expected to lower health plan medical costs by reducing medication errors and adverse drug events (ADE) by improved legibility, accurate drug dosages and drug interaction checking.
- Improve the procedures related to recovery of funds from audits, investigations, and rate changes.

The most pressing objective for the Medicaid agency is to find alternatives for the overall structure of the Division of Medicaid program to make it affordable for the State of Mississippi. The following pages are specific areas we believe will provide savings and/or program improvements.

Comment [E1]: Done. Improvements to program are noted below as part of performance objectives.

3. **Performance Effectiveness Objectives for each Program for SFY 2013 through SFY 2017**

SFY 2013

Medical Services Program:

1. Increase Medicaid enrollees to ensure all eligible Mississippi residents have health coverage.
2. Accelerate and improve the appeals hearing process for rate setting adjustments, audits, and investigations resulting in more rapid recovery of overpayments owed to the Division of Medicaid.
3. Promote and enhance the beneficiary's knowledge base of the Division of Medicaid program and services as well as promote healthy lifestyle choices and wellness activities through increasing educational community outreach programs by 10% and speaking to an additional 10% of Division of Medicaid beneficiaries reached during the last fiscal year.
 - The Division of Medicaid monitors current health care related media events pertaining to our program and chooses a topic for mass media distribution that is germane. Our goal is to correct any misinformation and to educate the public to the benefits available to qualified applicants.
 - The Division of Medicaid participates in community outreach events, reaching all categories of Division of Medicaid beneficiaries. The following are some examples of the community outreach programs attended by the Division of Medicaid throughout the year:
 - Health Fairs
 - Adult Wellness Expositions
 - Children Wellness Expositions
 - Parent Orientations
 - Senior Health Fairs
 - Cancer Forums
 - Veterans Trainings
 - The Division of Medicaid monitors and responds to Web Inquiries throughout the year.
4. Increase provider participation and provider training opportunities in the Medicaid program by both enhanced communication and active outreach efforts to Medicaid providers and potential providers:
 - Mississippi Cool Kids – Maintain the outreach efforts and technical assistance bestowed to providers to promote “Early and Periodic Screening, Diagnosis and Treatment” (EPSDT):
 - Provider Enrollment – recruit and enroll new providers in the early periodic screening & diagnostic treatment MS Cool Kids Program.

- MS Cool Kids Referrals – mail referrals, to providers, at the request of eligible Medicaid beneficiaries.
 - Perinatal High Risk Management/Infant Services System (PHRM/ISS) – Initiate and impart outreach and/or technical assistance to Medicaid providers.
 - Provide additional workshops
 - Maintain and monitor hours of provider call centers.
 - Strengthen communication between Medicaid staff and providers to exchange knowledge for improved service delivery.
5. Promote screenings and medical checkups to enhance the health of beneficiaries and decrease medical costs through community outreach programs. Success will be measured by an increase in the number of adult and child physical exams.
 6. Use EHR software and data to monitor emergency room (ER) visits and patterns.
 7. Encourage participation by hospitals in reducing the number and cost of emergency room (ER) visits by diverting ER visitors to less expensive care venues, as appropriate.
 8. Review locations and hours of outstationed eligibility workers. DOM will monitor the activity of each site monthly and ensure maximum utilization by redirecting applications and reviews to the sites closest to the individual's home. The concept of out-stationing eligibility workers may require modification under healthcare reform as new mandates may require replacing technology with direct contact.
 9. Continue to maximize all federal and supplemental drug rebates.
 10. Improve the Mississippi Coordinated Access Network (MississippiCAN), a Coordinated Care Program for Division of Medicaid beneficiaries and
 - Maintain contracts with Coordinated Care Organizations (CCOs) on a full-risk capitated basis to provide to targeted beneficiaries comprehensive services through an efficient, cost effective system of care.
 - Connect the targeted beneficiaries with a medical home, increasing access to providers and improving beneficiaries' use of primary and preventive care services to improve access to needed medical services.
 - Provide systems and supportive services, including disease state management and other programs, to improve quality of care and encourage beneficiaries to take increased responsibility for their health care.

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11. Maintain the contract to provide non-emergency transportation for end-stage renal disease patients to kidney dialysis locations. The population eligible for this service will continue to decline over time.
12. Continue and maintain the smoking cessation program. This program allows for the use of the most up-to-date prescription class of smoking cessation medication.
13. Facilitate the beneficiary recertification process by monitoring the mail recertification program for qualified beneficiaries and maintaining the number of hours of operation for outstationed recertification sites.
14. Implement APR-DRG's (All Patient Refined-Diagnostic Related Groups) for all Hospital Inpatient reimbursement.
15. Implement APC's (Ambulatory Payment Classification) for all Hospital Outpatient reimbursement. APC implementation would eliminate outdated reimbursement methodologies, which calculate outpatient reimbursement rates using data derived from Medicare cost reports. APC's would also eliminate the issues related to service locations. The APC system works in a complementary manner with APR-DRG's.

Medical Service Funding:

\$ 697,592,799	General
\$3,999,957,531	Federal (25.6825% average state rate)
<u>\$ 542,303,278</u>	Other
\$5,239,853,608 Total Medical Services SFY 2013	

Note: Medical Service expense is expected to increase overall, due to economic factors including eligibility growth, but increases will be mitigated by program savings where possible. Primary care physician fee increases mandated by the Patient Protection Affordable Care Act (PPACA) will be funded by the federal government in SFY2013.

Comment [E2]: This is not a true statement. DOM is required to reimburse PCPs at no less than 100% of the 2009 Medicare rates. AND, it is not to reimburse PCPs for all services, only certain services must be at this rate. See analysis provided to Margaret about this.

Administrative Services Program:

1. Reduce the amount spent on contractual services by filling vacant full-time positions in a timely manner.
2. Analyze constantly changing health care legislative proposals, regulations, and other related events to determine impacts on the Medicaid Program and the budgeting process.
3. Continue the implementation of Electronic Health Records (EHR). Greater sharing of medical information among the Medicaid providers is anticipated to enhance quality of care and reduce medical errors, resulting in decreased health care costs.
4. Monitor Medicaid Incentive Program Incentive Payment Qualifications as they become

defined by the Centers for Medicare & Medicaid Services (CMS). To become eligible for incentive payments, the provider must demonstrate “meaningful use” of EHR technology through a means approved by the State and acceptable to the Secretary. “Meaningful use” is characterized by three components identified in the American Recovery Act of 2009. The criteria for meaningful use will be staged in three steps over a five year period.

5. Continue the multitude of program integrity activities already in place, which reduce risk of fraud, waste and abuse.
6. Meet National performance objectives of the Fraud Summit and the President’s Executive Order on reducing improper payments and eliminating fraud, waste and abuse. The Order, released November 2009, adopts a broad set of policies, including transparency with a focus on identifying and eliminating the highest improper payments, accountability for reducing improper payments among executive agencies and officials, and coordination of Federal, State and local government action. One of the key components of the Executive Order is a directive to gather input from stakeholders and State representatives. State Medicaid Directors and State personnel are expected to be among those asked to play significant roles. The Office of Management and Budget (OMB) will identify the programs with the largest improper payments and establish targets to reduce such payments in coordination with the respective programs/agencies. The MB will issue guidance and procedures for identifying and publicizing the list of entities that have received the greatest amount of outstanding improper payments. A working group consisting of Federal, State and local officials will recommend to OMB methods to improve the Federal Government’s measurement of access to the program by the beneficiaries intended for the program. Additionally, DOM will collaborate with the Department of Health and Human Services (HHS), the Centers for Medicare & Medicaid Services (CMS), and the Department of Justice (DOJ) to reduce improper payments made to individuals and businesses as program beneficiaries or contractors by escalating efforts to eliminate payment error, waste, fraud and abuse, while continuing to ensure it serves and provides access to its intended beneficiaries.
7. Ensure at least 90% of Medicaid applications and redeterminations are processed within the mandated standard of promptness. This will remain an important benchmark to maintain for the traditional Medicaid program after healthcare reform mandates an expansion of the program.
8. Maximize the use of federal funds available to the Division of Medicaid by continuing the research and grant/waiver application process.
9. Increase third party liability (TPL) recoveries by monitoring and tracking submitted recovery forms and continuing matches with other insurance companies and Medicare.
10. Monitor the fiscal agent call center by monitoring the abandonment rate and the average answer time.
11. Monitor the fiscal agent’s handling of clean claims by determining the number of claims processed within thirty (30) and ninety (90) days of claim receipt.

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12. Encourage and monitor the submission of electronic claims by the provider.
13. Maintain current information system to improve access to medical service data for evaluation through system analysis and updates.
14. Maintain and meet the internal control assessment requirements provided by the Department of Finance and Administration and completed by the Medicaid Bureau of Financial Reporting. Update written policies, procedures, and risk assessments for major accounting functions at the Division of Medicaid. Continue to evaluate risks and review existing controls to further strengthen our internal control structure.
15. Constantly look at ways to contain costs in all areas of the program. Continue to explore avenues for decreasing administrative expenditures without diminishing the services provided to beneficiaries, such as negotiating purchase contracts, monitoring vehicle usage and travel, and employing e-supply.
16. Monitor the cost of design, development, and implementation of the new MMIS by maintaining a channel of communication with the fiscal agent and CMS.
17. Properly staff the agency to ensure efficient and effective administration of the program.
18. Increase training efforts for existing staff on health care issues to help mitigate the loss of experienced staff to retirement and higher paying jobs.

SFY 2013 Administrative Services Funding

\$ 46,086,779	General
<u>\$123,195,496</u>	Federal
\$169,282,275	Total

Children’s Health Insurance Program:

1. Increase SCHIP enrollees to ensure all eligible children have health coverage.
2. Review locations and hours of outstationed eligibility workers. DOM will monitor the activity of each site monthly and ensure maximum utilization by redirecting applications and reviews to the site closest to the individual’s home. The concept of out-stationing eligibility workers may require modification under healthcare reform as new mandates may require replacing technology with direct contact.
3. Ensure at least 90% of Medicaid applications and redeterminations are processed within the mandated standard of promptness.

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CHIP Funding:	\$ 41,187,121	General
	<u>\$ 186,366,032</u>	Federal

\$ 227,553,153 Total

Home and Community Based Programs:

1. Improve access to home and community-based services to rebalance institutional long-term care with community long-term care options by contacting interested residents of long term care facilities to determine the potential for transition back to their community.
2. Expand and maintain the Mississippi Youth Program Around the Clock (MYPAC) Federal grant program. This program saves monies and increases the quality of care to youth and their families by providing psychiatric services in the home and community, as opposed to care provided in a psychiatric residential treatment facility (PRTF). This five-year grant will end during FY2013 and the phase-out of grant services will begin.
3. Increase the completion of admissions within thirty (30) days to 90%.
4. Fill all waiver slots available and approved by CMS.

HCBS Funding:	\$ 85,145,007	General
	<u>\$233,899,789</u>	Federal
	\$319,044,796	Total

SFY 2014

Medical Services Program:

1. Enroll Mississippi residents newly eligible for Medicaid beginning January 1, 2014. Federal mandates increase the population eligible for Medicaid effective January 1, 2014.
2. Accelerate and improve the appeals hearing process for rate setting adjustments, audits, and investigations resulting in more rapid recovery of overpayments owed to the Division of Medicaid.
2. Promote and enhance the beneficiary's knowledge base of the Division of Medicaid program and services as well as promote healthy lifestyle choices and wellness activities through increasing educational community outreach programs by 10% and speaking to an additional 10% of Medicaid beneficiaries reached during the last fiscal year.
 - Continue to monitor current health care related events.
 - Continue attending and generating beneficiary community outreach programs throughout the state of Mississippi. (See SFY 2013 for list of outreach events).
 - Continue to respond to Web Inquires.
3. Increase provider participation and provider training opportunities in the Division of Medicaid program by both enhanced communication and active outreach efforts to the

Division of Medicaid providers and potential providers:

- Mississippi Cool Kids – Maintain the outreach efforts and technical assistance bestowed to providers to promote “Early and Periodic Screening, Diagnosis and Treatment” (EPSDT):
 - Provider Enrollment – recruit and enroll new providers in the early periodic screening & diagnostic treatment MS Cool Kids Program.
 - MS Cool Kids Referrals – mail referrals, to providers, at the request of eligible Division of Medicaid beneficiaries.
 - Perinatal High Risk Management/Infant Services System (PHRM/ISS) – Initiate and impart outreach and/or technical assistance to the Division of Medicaid providers.
 - Provide additional workshops
 - Maintain and monitor hours of provider call centers.
 - Strengthen communication between Medicaid staff and providers to exchange knowledge for improved service delivery.
4. Promote screenings and medical checkups to enhance health of beneficiaries and decrease medical costs through community outreach programs. Success will be measured by an increase in the number of adult and child physical exams.
 5. Use EHR software and data to monitor emergency room (ER) visits and patterns.
 6. Encourage participation by hospitals in reducing the number and cost of emergency room (ER) visits by diverting ER visitors to less expensive care venues, as appropriate.
 7. Review locations and hours of outstationed eligibility workers. DOM will monitor the activity of each site monthly and ensure maximum utilization by redirecting applications and reviews to the sites closest to the individual’s home. The concept of out-stationing eligibility workers may require modification under healthcare reform as new mandates may require replacing technology with direct contact.
 8. Continue to maximize all federal and supplemental drug rebates.
 9. Maintain the Mississippi Coordinated Access Network (MississippiCAN), a Coordinated Care Program for Division of Medicaid beneficiaries.
 10. Maintain the contract to provide non-emergency transportation for end-stage renal disease patients to kidney dialysis locations. The population eligible for this service will continue to decline over time.
 11. Continue and maintain the smoking cessation program. This program allows for the use of the most up-to-date prescription class of smoking cessation medication.

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12. Facilitate the beneficiary recertification process by monitoring the mail recertification program for qualified beneficiaries and maintaining the number of hours of operation for outstationed recertification sites.
13. Implement changes in compliance with federal requirements mandated by the PPACA.
14. Use APR-DRG's (All Patient Refined-Diagnostic Related Groups) for all Hospital inpatient reimbursement.
15. Implement APC's (Ambulatory Payment Classification) for all Hospital Outpatient reimbursement. APC implementation would eliminate outdated reimbursement methodologies, which calculate outpatient reimbursement rates using data derived from Medicare cost reports. APC's would also eliminate the issues related to service locations. The APC system works in a complementary manner with APR-DRG's.

SFY 2014 Medical Services Funding

Medical Service expense is expected to increase overall, due to economic factors including eligibility growth, but increases will be mitigated by program savings where possible. Primary care physician fee increases mandated by the PPACA will be funded by the federal government in SFY 2014. In addition the federal government will fully fund the required expansion population in SFY2014. However, the transition of approximately 58% percent of CHIP enrollees to Medicaid will increase costs to the Medical Services program in SFY2014.

Comment [E3]: See same note as above about this.

Administrative Services Program:

1. Continue to monitor and manage contractual service(s) cost reductions.
2. Analyze constantly changing health care legislative proposals, regulations, and other related events to determine impacts on the Medicaid program and the budgeting process.
3. Continue the implementation of Electronic Health Records (EHR). Greater sharing of medical information among the Medicaid providers is anticipated to enhance quality of care and reduce medical errors, resulting in decreased health care costs.
4. Monitor Medicaid Incentive Program Payment Qualifications and continue making provider incentive payments.
5. Continue the multitude of program integrity activities already in place, which reduce risk of fraud, waste and abuse. Keep informed of national trends for identifying risk and innovative audit practices.
6. Meet National performance objectives of the Fraud Summit and the President's Executive Order on reducing improper payments and eliminating fraud, waste and abuse.

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7. Ensure at least 90% of Medicaid applications and redeterminations are processed within the mandated standard of promptness. This will remain an important benchmark to maintain for the traditional Medicaid program after healthcare reform mandates an expansion of the program.
8. Maximize the use of federal funds available to the Division of Medicaid by continuing the research and grant/waiver application process.
9. Increase the recovery of third party liability (TPL) funds.
10. Monitor the fiscal agent call center by monitoring the abandonment rate and the average answer time.
11. Monitor the fiscal agent's handling of clean claims by determining the number of claims processed within thirty (30) and ninety (90) days of claim receipt.
12. Encourage and monitor the submission of electronic claims by the provider.
13. Maintain current information system to improve access to medical service data for evaluation through system analysis and updates.
14. Maintain and meet the internal control assessment requirements provided by the Department of Finance and Administration and completed by the Medicaid Bureau of Financial Reporting. Maintain written policies, procedures, and risk assessments for major accounting functions at the Division of Medicaid. Continue to evaluate risks and review existing controls to further strengthen our internal control structure.
15. Constantly look at ways to contain costs in all areas of program. Continue to explore avenues for decreasing administrative expenditures without diminishing the services provided to beneficiaries, such as negotiating purchase contracts, monitoring vehicle usage and travel, and employing e-supply.
16. Monitor the design, development, and implementation of the new MMIS by maintaining a channel of communication with the fiscal agent, CMS and the legislature.
17. Evaluate staffing needs for the planning and implementation of the federal health care reform mandated by PPACA.
18. Increase training efforts for existing staff on health care issues to help mitigate the loss of experienced staff to retirement and higher paying jobs.

SFY 2014 Administrative Services Funding

The Division of Medicaid anticipates an increase in funding needs for the administration of health care reform requirements, as mandated by the PPACA. Additional resources will be required to enroll the new beneficiary populations and to transfer many CHIP enrollees to

Medicaid, beginning January 1, 2014.

Children's Health Insurance Program:

1. Increase SCHIP enrollees to ensure all eligible children have health coverage.
2. On January 1, 2014, transfer CHIP enrollees that have a family income under 138% of the federal poverty level (FPL) to Medicaid.
3. Review locations and hours of outstationed eligibility workers. DOM will monitor the activity of each site monthly and ensure maximum utilization by redirecting applications and reviews to the site closest to the individual's home. The concept of out-stationing eligibility workers may require modification under healthcare reform as new mandates may require replacing technology with direct contact.
4. Ensure at least 90% of Medicaid applications and redeterminations are processed within the mandated standard of promptness.

Funding:

Three main factors drive the State cost for CHIP, including enrollment, the per member per month capitation fee and the federal match rate. On January 1, 2014, approximately 58% of CHIP enrollees will transition to Medicaid coverage. This decrease in CHIP enrollment will decrease expenditures in the CHIP program. Overall costs to the state budget are not expected, because the enhanced CHIP federal match rate is expected to apply to enrollees transitioned to Medicaid.

Home and Community Based Programs:

1. Improve access to home and community-based services to rebalance institutional long-term care with community long-term care options by contacting interested residents of long term care facilities to determine their possible transition back to their community.
2. Complete the phase-out of the five-year Mississippi MYPAC Federal grant program.
3. Maintain the admissions completion rate at 90% within thirty (30) days of receipt.
4. Fill all slots approved by CMS.

Funding:

Funding for this program will vary based upon the approved slots, overall Medicaid funding, and participation in the programs.

FY 2015

Medical Services Program:

1. Increase Medicaid enrollees to ensure all eligible Mississippi residents have health coverage. Federal mandates increase the population eligible for Medicaid effective January 1, 2014.
2. Increase recovery of overpayments made to providers.
3. Promote and enhance the beneficiary's knowledge base of the Medicaid program and services offered through increasing community outreach programs by 10%.
4. Increase provider participation in the Division of Medicaid program by enhanced communication:
 - Additional workshops
 - Increase hours of provider call centers
 - Increase provider field representatives
 - Boost onsite visits
 - Strengthen communication between Medicaid staff and providers to exchange knowledge for improved service delivery.
5. Promote screenings and medical checkups to enhance health of beneficiaries and decrease medical costs. Success will be measured by an increase in the number of adult and child physical exams.
6. Use EHR software and data to monitor emergency room (ER) visits and patterns.
7. Encourage the participation by hospitals in reducing the number and cost of emergency room (ER) visits by diverting ER visitors to less expensive care venues, as appropriate.
8. Review locations and hours of outstationed eligibility workers. DOM will monitor the activity of each site monthly and ensure maximum utilization by redirecting applications and reviews to the sites closest to the individual's home. The concept of out-stationing eligibility workers may require modification under healthcare reform as new mandates may require replacing technology with direct contact.
9. Continue to maximize all federal and supplemental drug rebates.
10. Maintain the MississippiCAN program.

9. Maintain contracts to provide nonemergency transportation for end-stage renal disease patients to kidney dialysis locations. The population eligible for this service will decline over time.
10. Continue and maintain the smoking cessation program. This program allows for the use of the most up-to-date prescription class of smoking cessation medication.
12. Monitor the recertification process for DOM beneficiaries for inconsistencies and complexity.
13. Implement health care reform in compliance with federal requirements, as required by the PPACA.
14. Use APR-DRG's (All Patient Refined-Diagnostic Related Groups) for all Hospital reimbursement and use APC's (Ambulatory Payment Classification) for all Hospital Outpatient reimbursement.

Funding:

The Division of Medicaid will continue to recommend changes to the program that represent cost savings without negative impact on quality and access to care for those eligible for Medicaid services. In SFY2015 the expansion population required by the PPACA will be funded 100% by the federal government. In addition, the required increase in payments to primary care physicians will be federally funded through December 31, 2014. The State will begin incurring costs related to the increased physician payments January 1, 2015.

Administrative Services Program:

1. Continue to monitor and manage contractual service(s) cost reductions.
2. Analyze constantly changing health care legislative proposals, regulations, and other related events to determine impacts on the Medicaid Program and the budgeting process.
3. Continue the implementation of Electronic Health Records (EHR). Greater sharing of medical information among the Medicaid providers is anticipated to enhance quality of care and reduce medical errors, resulting in decreased health care costs.
4. Monitor Medicaid Incentive Program Payment Qualifications and continue payments to eligible providers.
5. Continue the multitude of program integrity activities already in place, which reduce risk of fraud, waste and abuse. Keep informed of national trends for identifying risk and innovative audit practices.
6. Meet National performance objectives of the Fraud Summit and the President's Executive Order on reducing improper payments and eliminating fraud, waste and abuse.
7. Ensure at least 90% of Medicaid applications and redeterminations are processed within

the mandated standard of promptness. This will remain an important benchmark to maintain for the traditional Medicaid program after healthcare reform mandates an expansion of the program.

8. Maximize the use of federal funds available to the Division of Medicaid by continuing the research and grant/waiver application process.
9. Increase the recovery of third party liability (TPL) funds.
10. Monitor the fiscal agent call center by monitoring the abandonment rate and the average answer time.
11. Monitor the fiscal agent's handling of clean claims by determining the number of claims processed within thirty (30) and ninety (90) days of claim receipt.
12. Encourage and monitor the submission of electronic claims by the provider.
13. Maintain current information system to improve access to medical service data for evaluation through system analysis and updates.
14. Maintain and meet the internal control assessment requirements provided by the Department of Finance and Administration and completed by the Medicaid Bureau of Financial Reporting. Maintain written policies, procedures, and risk assessments for major accounting functions at the Division of Medicaid. Continue to evaluate risks and review existing controls to further strengthen our internal control structure.
15. Constantly look at ways to contain costs in all areas of program. Continue to explore avenues for decreasing administrative expenditures without diminishing the services provided to beneficiaries.
16. Add staff and training as needed to implement program changes as required by the federal PPACA.

Funding:

Administrative services funding should decrease overall due to the completion of the MMIS implementation. Other costs are expected to remain steady.

Children's Health Insurance Program:

1. Increase SCHIP enrollees to ensure all eligible children have health coverage.
2. Review locations and hours of outstationed eligibility workers. DOM will monitor the activity of each site monthly and ensure maximum utilization by redirecting applications and reviews to the site closest to the individual's home. The concept of out-stationing eligibility workers may require modification under healthcare reform as new mandates may require replacing technology with direct contact.
3. Ensure at least 90% of Medicaid applications and redeterminations are processed within

the mandated standard of promptness.

Funding:

Three main factors drive the State cost for CHIP, including enrollment, the per member per month capitation fee and the federal match rate. The enrollment, the capitation fee and the state match requirement are all expected to increase in SFY2015, over SFY2014 year-end factors.

Home and Community Based Programs:

1. Improve access to home and community-based services to rebalance institutional long-term care with community long-term care options by contacting interested residents of long term care facilities to determine their possible transition back to their community.
2. Maintain the admissions completion rate at 90% within thirty (30) days of receipt.
3. Fill all slots approved by CMS.
- 4.

Funding:

Funding for this program will vary based upon the approved slots, overall Medicaid funding, and participation in the programs.

FY 2016

Medical Services Program:

1. Increase Medicaid enrollees to ensure all eligible Mississippi residents have health coverage.
2. Increase recovery of overpayments made to providers.
3. Promote and enhance the beneficiary's knowledge base of the Division of Medicaid program and services offered through increasing community outreach programs by 10%.
4. Increase provider participation in the Division of Medicaid program by enhanced communication:
 - Additional workshops
 - Increase hours of provider call centers
 - Increase provider field representatives
 - Boost onsite visits.
 - Strengthen communication between Medicaid staff and providers to exchange knowledge for improved service delivery.

5. Promote screenings and medical checkups to enhance the health of beneficiaries and decrease medical costs. Success will be measured by an increase in the number of adult and child physical exams.
6. Use EHR software and data to monitor emergency room (ER) visits and patterns.
7. Encourage the participation by hospitals in reducing the number and cost of emergency room (ER) visits by diverting ER visitors to less expensive care venues, as appropriate.
8. Continue to maximize all federal and supplemental drug rebates.
9. Maintain the MississippiCAN program.
8. Maintain contracts to provide nonemergency transportation for end-stage renal disease patients to kidney dialysis locations.
9. Continue and maintain the smoking cessation program. This program allows for the use of the most up-to-date prescription class of smoking cessation medication.
11. Monitor the recertification process for DOM beneficiaries for inconsistencies and complexity.
12. Implement changes, as required by the federal PPACA.
13. Review locations and hours of outstationed eligibility workers. DOM will monitor the activity of each site monthly and ensure maximum utilization by redirecting applications and reviews to the sites closest to the individual's home. The concept of out-stationing eligibility workers may require modification under healthcare reform as new mandates may require replacing technology with direct contact.

Funding:

The Division of Medicaid will continue to recommend changes to the program that represent cost savings without negative impact on quality and access to care for those eligible for Medicaid services. In SFY2016 the expansion population required by the PPACA will be funded 100% by the federal government. However, the State will incur costs related to the increased physician payments for all of SFY2016.

Administrative Services Program:

1. Continue to monitor and manage contractual service(s) cost reductions.
2. Analyze constantly changing health care legislative proposals, regulations, and other related events to determine impact on the Division of Medicaid program and the budgeting process.
3. Continue the implementation of Electronic Health Records (EHR). Greater sharing of medical information among the Medicaid providers is anticipated to enhance quality of care and reduce medical errors, resulting in decreased health care costs.

4. Monitor Medicaid Incentive Program Incentive Payment Qualifications and continue payments to eligible providers.
5. Continue the multitude of program integrity activities already in place, which reduce risk of fraud, waste and abuse.
6. Meet National performance objectives of the Fraud Summit and the President's Executive Order on reducing improper payments and eliminating fraud, waste and abuse.
7. Ensure at least 90% of Medicaid applications and redeterminations are processed within the mandated standard of promptness. This will remain an important benchmark to maintain for the traditional Medicaid program after healthcare reform mandates an expansion of the program.
8. Maximize the use of federal funds available to the Division of Medicaid by continuing the research and grant/waiver application process.
9. Increase the recovery of third party liability (TPL) funds.
10. Monitor the fiscal agent call center by monitoring the abandonment rate and the average answer time.
11. Monitor the fiscal agent's handling of clean claims by determining the number of claims processed within thirty (30) and ninety (90) days of claim receipt.
12. Encourage and monitor the submission of electronic claims by the provider.
13. Maintain current information system to improve access to medical service data for evaluation through system analysis and updates.
14. Maintain and meet the internal control assessment requirements provided by the Department of Finance and Administration and completed by the Medicaid Bureau of Financial Reporting. Maintain written policies, procedures, and risk assessments for major accounting functions at the Division of Medicaid. Continue to evaluate risks and review existing controls to further strengthen our internal control structure.
15. Constantly look at ways to contain costs in all areas of program. Continue to explore avenues for decreasing administrative expenditures without diminishing the services provided to beneficiaries, such as negotiating purchase contracts, monitor vehicle usage and travel, and e-supply.
16. Add and train staff as needed to implement health care reform mandates, as required under the PPACA.

Funding:

Costs are expected to remain steady.

Children’s Health Insurance Program:

1. Increase SCHIP enrollees to ensure all eligible children have health coverage.
2. Review locations and hours of outstationed eligibility workers. DOM will monitor the activity of each site monthly and ensure maximum utilization by redirecting applications and reviews to the site closest to the individual’s home. The concept of out-stationing eligibility workers may require modification under healthcare reform as new mandates may require replacing technology with direct contact.
3. Ensure at least 90% of Medicaid applications and redeterminations are processed within the mandated standard of promptness.

Funding:

Three main factors drive the State cost for CHIP, including enrollment, the per member per month capitation fee and the federal match rate. The federal match rate for Mississippi’s CHIP program will increase to 100% beginning on October 1, 2015. Mississippi will incur State share costs only for the first quarter of SFY2016.

Home and Community Based Programs:

1. Improve access to home and community-based services to rebalance institutional long-term care with community long-term care options by contacting interested residents of long term care facilities to determine their possible transition back to their community.
2. Maintain the admissions completion rate at 90% within thirty (30) days of receipt.
3. Fill all slots approved by CMS.

Funding:

Funding for this program will vary based upon the approved slots, overall Medicaid funding, and participation in the programs.

FY 2017

Medical Services Program:

1. Increase Medicaid enrollees to ensure all eligible Mississippi residents have health coverage.
2. Increase recovery of overpayments made to providers.
3. Promote and enhance the beneficiary’s knowledge base of the Division of Medicaid program and services offered through increasing community outreach programs by 10%.
4. Increase provider participation in the Division of Medicaid program by enhanced communication:

- Additional workshops
 - Increase hours of provider call centers
 - Increase provider field representatives
 - Boost onsite visits.
 - Strengthen communication between Medicaid staff and providers to exchange knowledge for improved service delivery.
5. Promote screenings and medical checkups to enhance the health of beneficiaries and decrease medical costs. Success will be measured by an increase in the number of adult and child physical exams.
 6. Use EHR software and data to monitor emergency room (ER) visits and patterns.
 7. Encourage the participation by hospitals in reducing the number and cost of emergency room (ER) visits by diverting ER visitors to less expensive care venues, as appropriate.
 8. Continue to maximize all federal and supplemental drug rebates.
 9. Maintain the MississippiCAN program.
 10. Maintain contracts to provide nonemergency transportation for end-stage renal disease patients to kidney dialysis locations.
 11. Continue and maintain the smoking cessation program. This program allows for the use of the most up-to-date prescription class of smoking cessation medication.
 12. Monitor the recertification process for DOM beneficiaries for inconsistencies and complexity.
 13. Implement changes, as required by federal law under the PPACA.
 14. Review locations and hours of outstationed eligibility workers. DOM will monitor the activity of each site monthly and ensure maximum utilization by redirecting applications and reviews to the sites closest to the individual's home. The concept of out-stationing eligibility workers may require modification under healthcare reform as new mandates may require replacing technology with direct contact.

Funding:

The Division of Medicaid will continue to recommend changes to the program that represent cost savings without negative impact on quality and access to care for those eligible for Medicaid services. For the first half of SFY2017, the expansion population required by the PPACA will be funded 100% by the federal government. The FMAP from January through June, 2017 for the expansion population will decrease to 95%, which will increase the cost to the State for the Medical Services Program. In addition, the State will incur costs related to the increased physician payments for all of SFY2017.

Administrative Services Program:

1. Continue to monitor and manage contractual service(s) cost reductions.
2. Analyze constantly changing health care legislative proposals, regulations, and other related events to determine impact on the Division of Medicaid program and the budgeting process.
3. Continue the implementation of Electronic Health Records (EHR). Greater sharing of medical information among the Medicaid providers is anticipated to enhance quality of care and reduce medical errors, resulting in decreased health care costs.
4. Monitor Medicaid Incentive Program Incentive Payment Qualifications and continue payments to eligible providers.
5. Continue the multitude of program integrity activities already in place, which reduce risk of fraud, waste and abuse.
6. Meet National performance objectives of the Fraud Summit and the President's Executive Order on reducing improper payments and eliminating fraud, waste and abuse.
7. Ensure at least 90% of Medicaid applications and redeterminations are processed within the mandated standard of promptness. This will remain an important benchmark to maintain for the traditional Medicaid program after healthcare reform mandates an expansion of the program.
8. Maximize the use of federal funds available to the Division of Medicaid by continuing the research and grant/waiver application process.
9. Increase the recovery of third party liability (TPL) funds.
10. Monitor the fiscal agent call center by monitoring the abandonment rate and the average answer time.
11. Monitor the fiscal agent's handling of clean claims by determining the number of claims processed within thirty (30) and ninety (90) days of claim receipt.
12. Encourage and monitor the submission of electronic claims by the provider.
13. Maintain current information system to improve access to medical service data for evaluation through system analysis and updates.
14. Maintain and meet the internal control assessment requirements provided by the Department of Finance and Administration and completed by the Medicaid Bureau of Financial Reporting. Maintain written policies, procedures, and risk assessments for major accounting functions at the Division of Medicaid. Continue to evaluate risks and review existing controls to further strengthen our internal control structure.
15. Constantly look at ways to contain costs in all areas of program. Continue to explore

avenues for decreasing administrative expenditures without diminishing the services provided to beneficiaries, such as negotiating purchase contracts, monitor vehicle usage and travel, and e-supply.

16. Add and train staff as needed to implement changes required by the federal PPACA.

Funding:

Costs are expected to remain steady.

Children's Health Insurance Program:

1. Increase SCHIP enrollees to ensure all eligible children have health coverage.
2. Review locations and hours of outstationed eligibility workers. DOM will monitor the activity of each site monthly and ensure maximum utilization by redirecting applications and reviews to the site closest to the individual's home. The concept of out-stationing eligibility workers may require modification under healthcare reform as new mandates may require replacing technology with direct contact.
3. Ensure at least 90% of Medicaid applications and redeterminations are processed within the mandated standard of promptness.

Funding: The federal match rate for Mississippi's CHIP program will increase to 100% beginning on October 1, 2015. There will be \$0 State share for the CHIP program in SFY2017.

Home and Community Based Programs:

1. Improve access to home and community-based services to rebalance institutional long-term care with community long-term care options by contacting interested residents of long term care facilities to determine their possible transition back to their community.
2. Maintain the admissions completion rate at 90% within thirty (30) days of receipt.
3. Fund and fill all slots approved by CMS.

Funding:

Funding for this program will vary based upon the approved slots, overall Medicaid funding, and participation in the programs.

4. Significant External Factors Which May Affect Levels of Performance

- According to the Department of Health and Human Services 2008 Actuarial Report on the Financial Outlook for Medicaid prepared by the Centers for Medicare and Medicaid

Services (CMS) (1), “From its inception, the cost of the Medicaid program has generally increased at a significantly faster pace than the U.S. economy. This cost pattern is not unique to Medicaid. Costs for virtually every form of health insurance, public and private, have increased rapidly, reflecting growth in the number of insured persons, wage increases and price inflation in the medical sector, provision of a greater number of medical services, and the development of new, better, more complex and generally more expensive services. Determining how to optimally balance our collective demand for the best health care possible with our not-unlimited ability to fund such care through private and public efforts represents one of the most challenging policy dilemmas facing the Nation.”

- The Affordable Care Act (ACA), signed into law March of 2010, will have long reaching effect on the Division of Medicaid program. Provisions of the new reform will become effective at various times until January 1, 2014 when all aspects other than State funding become effective.

5. Agency's Internal Management Control System Utilized to Evaluate its Performance Achievements in Relationship to Targeted Performance Levels.

The Division of Medicaid has developed an experienced, capable unit of data processing staff and analysts, and is in a position to provide extensive data analysis as a basis for health policy. The tracking of this information is carried out within the agency's Information System which allows for the determination of payment to providers and lends itself to the accounting of expenditures and the tracking of trends. A new DSS is needed to improve data availability for analysis and increased demands due to health care reform as mandated by the PPACA.

The Division of Medicaid is also working to strengthen its Program Integrity Unit addressing fraud and abuse, and a Contracts Monitoring Team reviewing cost reports, cost allocations, and program services.

¹ 2008 Inaugural edition of the “Medicaid Actuarial Report on the Financial Outlook for Medicaid” Prepared by: Christopher J. Truffler, F.S.A., John D. Klemm, Ph.D., A.S.A., M.A.A.A., E. Dirk Hoffman and Christian J. Wolfe of the Office of the Actuary, Centers for Medicare & Medicaid Services, United States Department of Health & Human Services.